
Council Meeting

of

NEW JERSEY ADVISORY COUNCIL ON ELDER CARE

“Testimony concerning health care and caregiving for the elderly”

LOCATION: Francis E. Parker Memorial Home
Piscataway, New Jersey

DATE: March 5, 1999
10:00 a.m.

MEMBERS OF COUNCIL PRESENT:

Assemblywoman Carol J. Murphy, Chair
Assemblyman Samuel D. Thompson
Assemblyman Louis A. Romano
Ruth M. Reader
Theresa L. Edelstein
John Michael Heath
Renee W. Michelsen
Roberto Muniz



ALSO PRESENT:

Irene M. McCarthy
Office of Legislative Services
Council Aide

Meeting Recorded and Transcribed by
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ASSEMBLYWOMAN CAROL J. MURPHY (Chair): Ladies and gentlemen, I want to begin the meeting if you don't mind; and before I ask Roberto to speak, Assemblyman Romano had a question.

ASSEMBLYMAN ROMANO: I have a thought as I go through this and I learn more and more and, then, as an Assemblyman where I have constituents, the hue and cry today is that people on Medicare are looking for Medicare to pay for the cost of prescriptions. Just not enough money to go around, but-- Right now, the State as a means test -- uses the Medicaid limits for the Medicaid purposes and the PAAD Program to qualify for the hearing aid and for the life line, which in my own mind are totally unrealistic. The whole world does not just stay under the PAAD Program and could use assistance.

Do you believe that there might be some sort of a benefit where as you go up the ladder and find this-- Let's say, they made it 25,000. Those people above 25,000 or above the PAAD limits to 25,000 might be able to have drugs but with a higher co-pay. I don't understand why this is happening. Everybody has a means test of the PAAD Program.

Right now, I'm totally off the topic. I have my round-the-clock discount bill for senior citizens, and it's sitting in the Senate. It was up on the board. They held it because some people said (a) we don't want people with diamond rings getting on the bus at half fare. It's a little preposterous because, if you have that kind of money, you don't get on the bus. And where's the means test? So, as I say, the Medicaid cusp/the PAAD cusp I don't think are sufficient for us to really do other things for seniors. I'm not talking about a big give-a-way program here. What I'm just saying is, when you just buy in

volume and when the State operates it, whatever the case may be, I don't care if the co-pay is \$10, let's say, on a certain medicine up to a point. Could be \$20 on medicines over \$100 or whatever the case is. Just think about it, and I don't know if you have found any interest in something like that. I know I'm interested in it, and I really don't know how to articulate it all, but the whole world doesn't operate under the PAAD limits. That's all, and I won't take up more of your time.

ASSEMBLYWOMAN MURPHY: Thank you, Lou, and we will think about it because it's a good issue -- a good solid issue.

Roberto.

MR. MUNIZ: Great.

ASSEMBLYWOMAN MURPHY: Thank you for the tour. It's a very beautiful facility.

MR. MUNIZ: Thank you.

Do you want me to do it from here? (referring to panel seat)

ASSEMBLYWOMAN MURPHY: Wherever you choose to be. You may be wherever you are comfortable.

MR. MUNIZ: This is fine. Great.

Madam Chairperson, members of the Advisory Council on Elder Care, good morning. My name is Roberto Muniz, and I'm here this morning to provide testimony not as a member of the Council, but as a provider of long-term care and as the President of the American College of Health Care Administrators for the New Jersey Chapter. We thank you for the opportunity to provide testimony this morning.

The American College of Health Care Administrators is the professional association for nursing home administrators throughout the country. The New Jersey Chapter represents approximately 250 members, all of them administrators.

At the outset, I would like to say that we are supportive of the increased attention and the development of community-based alternatives to elder care and their families. Nursing homes, however, are critical to the overall system of care, particularly when an older person can no longer safely live in a more independent setting or when a family caregiver can no longer safely manage the care of a loved one.

The nursing home meets residents and their families and friends at a very vulnerable time in their lives. Usually, this is after they have had many encounters with other parts of the health-care system. They come with many emotions -- anxiety, guilt, concern, failure, love, and respect -- and we are entrusted with the care of the residents and the family at this time. Within the walls of our nursing homes are caregivers, our staff, who come from various backgrounds, live by different cultural norms, and who have different levels of knowledge and expertise. Beyond the obvious caregivers who are nurses and nursing assistants are the many others such as housekeepers, transporters, cooks, recreation workers, and yes, administrators.

By and large, New Jersey nursing homes are among the best in the country with approximately 70 percent achieving a deficiency-free status on their last annual inspection during the first six months of 1998 and more than 80 percent meeting the advisory standards. And this is great timing because we had the report card that came out not long ago.

ASSEMBLYWOMAN MURPHY: That's right.

MR. MUNIZ: Does this mean that there are no problems in some facilities? Of course not, and we can all agree that even one instance of poor care is too many. However, there are countless and many more instances of sensitive, high-quality, dedicated care rendered by heroes every day -- our staff in partnership with the families and friends of residents.

As you have heard from many others, there are needs for training and support of all levels of nursing facilities. There are also areas of expertise that nursing home staff can offer to others. The American College of Health Care Administrators believe that part of the answer for the future is partnership and integration among services provided. State policy must foster the sharing of resources, knowledge, and expertise rather than treating provider entities separately. Together we should look for ways to remove the regulatory roadblocks to achieve greater efficiency in admissions practices and case management, for example.

Nursing homes and administrators can no doubt learn from the financial efficiencies achieved by hospitals, while we can offer expertise in the use of alternatives to restraints. Nursing homes can learn much about the use of computer technology and the pitfalls to avoid, while hospitals can learn about nutritional approaches for the geriatric patients. This is only the tip of the iceberg.

I have been very brief today with my statement. I'd rather have the health-care providers, family members, and residents themselves talk to us about their experience in nursing homes.

Thank you.

ASSEMBLYWOMAN MURPHY: Thank you very much, Roberto. And that brings us to the part of the program, I believe--

MR. MUNIZ: Right. The schedule, the agenda.

ASSEMBLYWOMAN MURPHY: Right.

MS. EDELSTEIN: Do you have a particular order that you would like the witnesses to appear?

ASSEMBLYWOMAN MURPHY: No.

MS. EDELSTEIN: Then, Tom Kenney, I think-- We'll start off with Tom, who is also an administrator, and then we'll go to the other members of his staff and the residents.

THOMAS P. KENNEY: Good morning. My name is Tom Kenney. I'm the Administrator at Kessler Care Center at Cedar Grove. Roberto and I go back about 10 years together working together, and it's now very difficult to follow you, but I'll try.

I've been a licensed administrator about 20 years. I've worked in the government sector. I've worked in the private sector. I've worked in the for profit and nonprofit sector. I've worked in facilities that have been licensed over 500 beds and facilities licensed at 100 beds. And as an administrator, and there are other administrators in the room, we're concerned. We're concerned about the future and where we're going.

As a boy growing up in New Jersey, we looked at nursing homes, and we thought they were homes for the aged. There were convalescent homes. And our industry has changed. And I'll tell you I'm very proud -- very proud -- to be an administrator in New Jersey today. The standards that we hold through the college and with the partnership of the State Department of

Health and Senior Services is exemplary. I have always considered a State survey a pleasure to be a part of because the members of the team coming in to review my facilities have always been positive and very helpful to myself, as an administrator, but also to my residents.

I'm going to talk briefly on two words today, and I want to ask you to consider these two words: reasonable expectations. Through life we go and we do many things. And when I was in college, I had a course at 8:00 in the morning on business law. One thing that I remember from that very early course was the reasonable-man theory. What is reasonable for us to do? What is reasonable for us to be a part of this industry today that is drastically changing?

No one asks to be placed in a nursing home. No one rose up and said, "When I turn 85 years old, I want to be a nursing home resident." No one asks to develop Alzheimer's or cancer or heart disease. The nursing home industry today would like to close our doors and walk away if the families and the health-care profession could take care of all of us. But reality and history has shown that this is not possible.

We are here today to serve as a part of a continuum of care. We have a very valid role to serve today. In my facility alone, I have an age population going from 24 years old to 104 years old. I'm not just a home for the aged. I'm a health-care facility. I'm licensed by the State of New Jersey to manage that health-care facility, and I take honor and pride in being a licensed administrator.

We all came here this morning in cars, and we had a reasonable expectation that when we got in our car that that car was going to start, and

for all of us it did. And there are many times when we get in that car in the morning that it might not start, but that's a part of life. Everything is not perfect, and the long-term care industry and the health-care industry is not perfect. Today, with your assistance, we all can look at the opportunities and make adjustments to make it better for the future.

It's not an easy environment to work in or be a part of. We have assisted living on one side. They're saying, "We're better than nursing homes." We have hospitals on the other side that are now throwing people out the doors quickly and then expecting us in the nursing home environment to provide a quality of care that we're not accustomed to provide, but we will do it. We will do it because we have committed staff, we are compassionate, and we have quality owners and operators who are really dedicated to this field.

We want to work with the families. We want them to be a part of our world. The phrases that we've taken over with OBRA, the Federal regulations since 1987, talks about quality of life and quality of care. We support that concept, but anytime you look for quality, quality has a price. None of us came here today all driving 30-year-old Volkswagen Beetles. We all have a quality of standard of life that we want to live up to. And we, as administrators, are committed to that quality of life for every resident, but also for our staff members who work in that environment. Bless them, for it is very difficult at times to do the work that they have to do.

I'm proud to be there, but I'm not also an administrator. The last meeting I had last night in my building was with my aunt, an Alzheimer's resident admitted into my building. Where does she go? And I probably cared for over my career about 10,000 residents, and dealing with family is very

difficult. Here's a woman who knows she has Alzheimer's, knows that she can't be home, but doesn't know where she's going to go. And without a nursing home and without our environment, who would take care of her?

Generations ago, and I can remember her mother, there was 11 children. There was almost a calendar, and this child and this grandchild and this one -- everyone was on the calendar. My wife would have to have Friday night with another cousin. We don't have that today. We have accepted our responsibility as family, and we must continue to do that.

And I ask the State, through our legislators and the other professionals in our field, to look at us. Look at us and help us. Our numbers are not going to decrease, and someday, God forbid, it might be one of us in this room that are professionals today that have to care for one another.

Madam Chair, I thank you for the opportunity, and we certainly, as a part of Kessler, we extend any helping hand we can to help you, the Governor, and this State make quality of health care in a long-term care setting better today than it was yesterday.

Thank you.

ASSEMBLYWOMAN MURPHY: Can I ask a question?

MR. KENNEY: Yes.

ASSEMBLYWOMAN MURPHY: Kessler in my mind has always connotated rehabilitative care, so in your facility do you also handle rehabilitative care as well as nursing care?

MR. KENNEY: Kessler Rehab Corporation saw to get into the long-term care market about four years ago.

ASSEMBLYWOMAN MURPHY: Okay.

MR. KENNEY: So we are licensed as a nursing facility. There are three of us in the Kessler Corporation. We do rehab. We do it under the concept of subacute care, but my building is 75 percent Medicaid. Kessler took on and purchased the old Essex County Geriatric Center, so we--

ASSEMBLYWOMAN MURPHY: Oh, that's where you are.

MR. KENNEY: That's where I am.

ASSEMBLYWOMAN MURPHY: Okay.

MR. KENNEY: And I have fortunately -- from the other side, I had spent about five years in Hudson County government at a facility called Meadow View, and we worked to privatize that. So that we can see that there is a changing market, and there are clients in our facilities today that I would never have dreamed of caring for when I sat for my license 20 years ago. I would have thought they would have been in an acute care hospital, the old med-surg units, but they're with us today.

We have an obligation, we have a responsibility to make sure that we have the right staff, the right commitment of staff, the right trained staff to care for these peg tubes and pick lines, etc., that a nursing home, a convalescent home would never have thought about. Yes, we do rehab.

ASSEMBLYWOMAN MURPHY: And may I also ask, are your residents more transient, or are they all long term? If they're there on sort of what would of been med-surg in past history, are they there for shorter periods or are most of them there for the long--

MR. KENNEY: Well, we're a facility in transition.

ASSEMBLYWOMAN MURPHY: Okay.

MR. KENNEY: When we took over in July of 1996, the average length of stay in an institutionalized setting was 33.5 years -- 33.5 years institutionalized.

ASSEMBLYWOMAN MURPHY: Wow.

MR. KENNEY: We now have a subacute unit of 55 beds that we will do hip replacements, we will do wound care, that we are Medicare certified, so they might be there 20. When you talk average length of stay, and government was very much a part of that-- We can think of the Marlboros and the Greystone Parks--

ASSEMBLYWOMAN MURPHY: Correct.

MR. KENNEY: --but now we're moving on. We're moving to the next century. That should not diminish our society's responsibility for care for the disabled or the elderly and to provide a quality of care because they cared for us as we were growing up. We should at least pay back and care for them, no matter what the illness is.

ASSEMBLYMAN ROMANO: Madam Chair.

You had indicated -- you said subacute, where we do hip replacements. You're not telling me that--

MR. KENNEY: I'm not a surgical center, but I will do--

ASSEMBLYMAN ROMANO: Oh, okay. You mean after the fact.

MR. KENNEY: --the rehab after, yes. And what you're seeing today, almost to the effect that the surgery is done in the emergency room and almost coming back to a subacute center without an extensive hospital stay.

ASSEMBLYWOMAN MURPHY: Right.

MR. KENNEY: Never dreamed of before.

ASSEMBLYWOMAN MURPHY: No. Many of the things we are faced with today are things we never dreamed of before.

ASSEMBLYMAN THOMPSON: You asked that we help. Do you have specific recommendations or--

MR. KENNEY: I have a statement that I will certainly provide to you. I think that we need to look at again reasonable expectations. Consider what is reasonable for us to receive in the form of payment to train people to care to be positive caregivers. We just can't pay the same amount of money to a certified nursing assistant that we pay for someone to hand out a hamburger at Burger King. We have to expect quality. We have to expect compassion. We have to expect a dialogue between the State of New Jersey and the various associations that are here in the room today. We have to expect that we will make mistakes, and we need to learn from those mistakes. And we need to stay with it because in the future, if we don't hang together and communicate as you're doing today, the elderly population -- and I'm pretty soon to be one--

ASSEMBLYWOMAN MURPHY: That's why we're here.

MR. KENNEY: --the elderly population as well as the disabled population is not going to have anyone to turn to because traditionally in the past government has always been that place of last resort. Everything cannot be reduced to dollars and cents. If society is going to move forward, we have to have the commitment to take care of all our members of society.

ASSEMBLYWOMAN MURPHY: As you have said, you have a component that would deal with what traditionally would have been med-surg. What other components do you have within your facility now?

MR. KENNEY: Well, we have a geri-psychiatric component.

ASSEMBLYWOMAN MURPHY: Okay, and that would be dementia related.

MR. KENNEY: Dementia related, Alzheimer's.

ASSEMBLYWOMAN MURPHY: Yes.

MR. KENNEY: We have basically a general long-term care component.

ASSEMBLYWOMAN MURPHY: Correct.

MR. KENNEY: We would like and will continue to focus more on the Alzheimer's situation, a disease that really is unknown, and where it will take us. We do the short-term therapies. We're doing a young adult population in one of the Kessler facilities that opened in July of last year -- is committed to the 24-year-old to 60-year-old population that are disabled and infirmed.

ASSEMBLYWOMAN MURPHY: Okay.

MR. KENNEY: On a long-term care setting, we look very aggressively to work with specialized housing because there are many times that people do not need to be kept in a long-term care site, but just need some minimal supervision.

ASSEMBLYWOMAN MURPHY: Correct.

MR. KENNEY: We work aggressively in our beginning dialogues with the assisted-living community, rather than fighting them, for that private-pay patient. We need to work with them to coordinate services. There needs to be a continuum of care.

ASSEMBLYWOMAN MURPHY: Correct. And in terms of specialized housing for people who might stay in their home, are you looking at home health care coming from the facility with the opportunity to move forward into the facility?

MR. KENNEY: I have staff on my payroll dedicated just to assist the transition from my site back into a home setting, yes.

ASSEMBLYWOMAN MURPHY: Okay. Thank you.

MR. KENNEY: Thank you.

MR. MUNIZ: You have testimony?

MR. KENNEY: I just want to-- (witness distributes testimony)

ASSEMBLYWOMAN MURPHY: Yes, please do.

MS. EDELSTEIN: I think next we will have Ruth Smith.

RUTH SMITH: Hello. My name is Ruth Smith. I'm 97 years of age, and I'm a resident in the Daughters of Israel Geriatric Center in West Orange. I'd like to tell you about the place, and I'm glad you're giving me this opportunity to speak on the subject.

First, I'll go to the basics, food and cleanliness. We are fed three good meals a day where we have the foods that we're supposed to get -- proteins, vegetables, starches, and fruits are available. We have a choice, too; if we don't like the particular thing, there's usually another choice of one or two, and I find that very good. As to cleanliness, we are showered from top to bottom (laughter), and the shower is great, feels wonderful on the body. If you like it hot-- I like it hot. Some don't. Dried all over and come back nice and clean, so clean we squeak. (laughter) And then, as I mentioned, we have-- Our linens are changed regularly once a week, no question about it. And if

clean linen is required because somebody had an accident, it will be done and done immediately. That takes care of the cleanliness part of it.

Now as to our entertainment, we have a calendar. Here it is. Here's one of them. (indicating calendar) This is for March.

ASSEMBLYWOMAN MURPHY: Okay.

MS. SMITH: Our own calendar setting forth the days of the month and the activities each week for that particular day. There's no compulsion to join. You do what you like, and we join in these different activities. There are a lot of people who like to play bingo, which doesn't happen to be my pleasure, but I like to go for the chorus because I like singing. So we are given an opportunity to join the chorus, and I'm very fortunate. I'm allowed to sing a solo sometimes. My family was on stage, more or less, and I guess I have that urge. (laughter) So I can do that.

Since I reached the age of 90, I've had articles published by the Reno Publishing Company of Reno, Nevada. I must have about 20 of them, and that was good because when I got my first check, I almost went through the ceiling. I hadn't earned anything since I was maybe 65, whatever it was. I was passed 90 when that happened.

There were other people, and I want to tell you about them. Our place has its arms wide open to receive people who are not as well adjusted to life, who cannot do as well, and who need assistance. It pleases me so much to see the assistance given. For example, in the dining room, some of them don't know how to cut their own food, and the waitresses will take care of them first, serve them their food, and cut the food for them to make sure that

they're able to eat before we get ours. And it doesn't matter because that's as it should be.

As far as, oh, yes, our accommodations. I have a large room, so has everyone there, with facilities of a bathroom immediately close. A large window sill on which I have my plants. I grow African violets. I have two beauties, purple and pink. I have a Christmas cactus and a vine that grows -- going all over the place. I'm afraid it's going to take over the room.

I will go on and speak about the entertainment we have. Every Sunday at 2:30 there is something going on in the auditorium, and everybody troops down to the auditorium -- not down, over to the auditorium -- to hear what's going on, and sometimes it's better and sometimes not as good. These are paid entertainers. But we do go, and it's good to get up and go and walk because it's necessary. There's music. We have those who can sing by themselves. They sing along. We have sing-a-longs. And we have the chorus. I don't know whether I mentioned the chorus -- I did -- which we practice on every Wednesday, and usually in a two- or three-month period we entertain with the songs. You'd be amazed at the songs we choose -- tells you how old we are -- like, (witness sings) "By the sea, by the beautiful sea. You and I, You and I, oh, how happy we'll be." Do you remember that?

ASSEMBLYWOMAN MURPHY: We do. (laughter)

MS. SMITH: So we entertain. And then those of us who have extra talent are given the opportunity to get on the stage and give a talent show. And I'm fortunate enough to have done that. It pleased me very much to give them a long poem, which I knew by memory, of the Vikings about a love story. It was very moving about a couple fleeing from an irate father, who

found their way to the shores here. This is really based on some history because Longfellow wrote a poem about it when they found that skeleton of somebody with crude armor and figured that he was one of the Vikings from the northland because they did come here before Columbus.

He starts with, "Speak, speak, thou fearful guest." He wants to hear the story, and the skeleton answers him. It's about 10 minutes in duration, and that was one of the things I did. And I've been there several times. It was great for me, and I love the place for that reason. A place that does things for people who cannot and for people who can. I want to tell you that for me--

Oh, by the way, we're weighed every month. (laughter) I don't like that. (laughter) And some of us come back after being weighed and don't want to tell. And if I have lost weight, I just don't mention it because they'll be jealous because I try to be kind.

We have -- before I go away from this place, I want to describe it. In the lobby, we have a very large screen for movies, and we have VCRs that fit in from 8:00 in the morning until 8:00 at night. If people are eager to see, they haven't anything else, they can sit there on comfortable chairs or on the couch and watch it. Also, on Saturdays, we have people who come with a guitar. These are two women -- Lisa is one and Francis is another -- who come and play their guitars, and we sing the old songs. It's such a good thing to sing because it lifts your spirits. I always feel good after a sing.

There's another thing. We also have a tremendous fish tank with all kinds of colored fish in it. When little children come to visit their old grandparents, they stand transfixed in front of the tank to watch those fish.

And I once asked Rhoda, who is one of our staff, have we ever had any young fish in here? And she said, "No. Never." And I said, why not? She said, "I don't know. We never had any young." I know why. These fish drop their eggs and the others eat it. That's how they nourish themselves among -- sort of a cannibal thing. I once had a fish tank. I had a fish tank which had live bearers. I had all kinds of fish. I decided I was going to rescue the babies when they were born because the older fish would come down and eat them, so I had a scoop. I took them up and I put them into the nursery tank which was inside the big fish tank. I had a population explosion. I decided not to do any more of that.

Another thing we had was one fish jumped for some reason out of the tank, and I got it back in, but it had this-- Its back was humped a little bit. And for some reason, it must have looked like a female because all the males were chasing it, but it wouldn't stop. I don't know what happened to it. It was an education in itself, except I'll end up by telling you about my fish tank.

I had a cat, and I decided that she would be interested in the tank. The tank stood about five feet above the ground on a bookcase, and it had a plate glass cover. I put her on top of the cover and she looked in. That poor thing was just overcome, so I decided to give her a chance, and I pushed the plate glass cover back a little bit, and she tried to catch them. She tried and tried, and I pushed it back more and more. I didn't realize that I had overdone it, and she fell into the tank and sprang out on the floor, the plate glass shattered all over, and that was the end of the cover. I had to say to myself, patience, patience, and I picked it up with cotton -- commercial cotton. It took the longest time. That was the end of my fish tank, but I was educated in fish.

ASSEMBLYWOMAN MURPHY: Thank you very much, Ms. Smith. Thank you so much. (applause)

May I ask you a question, Ms. Smith?

MS. SMITH: Yes.

ASSEMBLYWOMAN MURPHY: You write articles--

MS. SMITH: Yes.

ASSEMBLYWOMAN MURPHY: --about -- what subject do you write these articles--

MS. SMITH: The articles that they wanted was from old people who remembered happy incidents of their youth, and that's what it was.

ASSEMBLYWOMAN MURPHY: Thank you very much.

MS. SMITH: I'll only tell you about one.

ASSEMBLYWOMAN MURPHY: Okay, if that's a promise.

MS. SMITH: Would you like to hear? It was written by Ruth Smith, and it said, "Did my brother ever tell a lie? Never." I went to school at the time, I was six years old. My greatest fear was passing horses. I had a feeling that they were going to kill me. They were so big they would come up on the curb and kill me. I had to go to school. So I told my big brother who was twelve years old about my-- I said I was afraid of the horses. He said, "Ruthie, don't be afraid. If a horse puts his foot on the sidewalk, he'll drop dead." He didn't think so, but he told me that to comfort me.

So I'd pass a horse and say, "Just dare put your foot on the sidewalk. You'll drop dead." (laughter) One day I was walking along -- and that was several years later -- and I saw a horse with his foot on the sidewalk, and I waited for him to drop dead. (laughter) And he didn't drop dead.

(laughter) Well, my brother said, did I lose faith in my brother? I did not. If he told me the moon was made of cream cheese, I'd believe him. And that was my article.

ASSEMBLYWOMAN MURPHY: Well, that was a wonderful article. Thank you very much, Ruth, and I'm pleased that you shared it with us today.

Thank you.

Theresa.

MS. EDELSTEIN: Okay. Mr. Arthur Pamerleau.

A R T H U R P A M E R L E A U: Good morning. My name is Art Pamerleau. I'm from the Foothill Acres Nursing Home, and I'm to represent them at this meeting. I thank you for inviting me. I'm 80 years old -- I will be on June 2, and I enjoy living at Foothill Acres. I came in I was a basket case. My wife had just died after 54 years together, and I needed counseling. I was seeing objects that weren't there, and they took real good care of me. I had pneumonia besides, so I was a mess. But I've enjoyed every minute of my living there. They take good care of me. We have entertainment. We have games to play, large activity rooms, and nursing care is excellent.

Our director of the home is a wonderful person. I'm happy to be there, and I hope to stay there another few years anyway, but I have something I came across that I have to read to you if you don't mind for a minute. I was also chosen as the senior citizen of the year at that home, and I represented all of the New Jersey nursing homes down at Atlantic City and spoke to them down there. I'm quite certain that comedy and humor is a cure for all diseases, and I came up with this important new news release that I came across. And

it says, "Senior citizens are the nation's leading carriers of Aids: hearing aids, Band-Aids, Roloids, walking aids, medical aids, government aids, and most of all, monetary aids to their children. (laughter) The golden years have come at last. I cannot see. I cannot pee. I cannot chew. I cannot screw. My memory shrinks. My hearing stinks. No sense of smell. I look like hell. My body's drooping. I got trouble pooping. So golden years have come at last. Well, golden years, you can kiss my you-know-what." (laughter)

Thank you for the opportunity.

ASSEMBLYWOMAN MURPHY: It is probably just as well that you and Ruth don't live in the same place. (laughter)

Thank you very much. Thank you.

MS. EDELSTEIN: You can see why we wanted you to hear from the people who live there because they can represent the vitality of nursing homes far better than any administrator ever could.

Rose Majetich.

R O S E M A J E T I C H: You did that really good. (referring to pronunciation)

MS. EDELSTEIN: I was afraid I was going to really blow it. (laughter)

MS. MAJETICH: It's Rose Majetich, so that's good. I believe in visuals, and I'm not going to read all this to you, okay.

I have a different story. I have my parents, and I used to say, God is so good to me, I still have my parents. Well, it comes as mixed blessings because mom's 84 with Alzheimer's and my dad is 90 going blind. So we have our hands full. I'm the oldest of three children. My brother has sugar

diabetes, and he's had 19 laser surgeries on his eyes, so he has a lot of health problems. And my sister lives in Minnesota, and she's had two heart attacks. So I'm the healthiest.

We've had some problems in the past 10 years. Eight years ago, my father's house was destroyed by fire. And while they were rebuilding it, I had moved over here to New Jersey with Tupperware, and I would make trips back and forth with my husband. Then, seven years ago, my husband had his first and only attack. He died in his sleep, and it took me two years to get through that because there was a lot of steps to go through that I didn't realize I had to go through.

Eight or nine years ago, my mother's doctors were already talking to my brother and me about the dementia that my mother was having. Well, I think there's a lot of steps there, too, when you say you deny all the anger. No, this is not my mom, she's just forgetful, or she's just being argumentative or she's just doing things like this. My parents have been separated, also, for about 30 or 40 years, so that's probably why they're both alive yet. (laughter) Because I think they would have killed each-- No.

But anyway, my mom lived in an apartment with my aunt. My aunt was six years younger than my mother. She also has Alzheimer's. In one of my trips back home, I found out that my mother, at 83 years old, with no license and no insurance, had taken a truck from one of the men in the bar and drove him home because he was too drunk to drive. I went ballistic because I thought, my God, what if she had killed somebody? So I said to my brother, you have to control her. Well, it's kind of hard to control an 84-year-old woman with a real strong will.

Last spring my cousin Pattie called me from Florida and said that they were be putting my aunt in a nursing home because her condition had gotten a lot worse. I said, "Well, Pattie, give me time. I don't know what we're going to do with Mom. I don't know if I can bring her over here. I don't know if Arthur can handle her. I don't know what can happen with her." And last July we had a birthday party for both of my parents. All my children -- I have four children, five grandchildren -- we all went back to Pittsburgh. We had a nice birthday party at a restaurant.

Unfortunately, my mother doesn't remember any of it. She'll look at the pictures, and she doesn't even remember being there, and she don't remember my sister being there or anything. That's real hard to take, okay. She didn't recognize my children, and she had lived here in New Jersey for three years at the senior center over near me. She still doesn't remember a lot of my kids, and she'll say to my son, "Are you still single?" And he's got an eight-year-old daughter. He's been married about 10 years.

But anyway, I started to pack down my mother's apartment trying to figure out what we were going to do, and I was going to bring mom over to live with me. And yes, we found dog food in her cupboard, which was very upsetting. We also had a different problem. The living conditions were very bad. My aunt had a bar downstairs, and naturally, they would come in a spray to keep the place free of insects, and they would go upstairs. So my brother and I would go and we would spray, and they would go downstairs. So we had a little war going on. So I said to my brother, okay, this is it. I'm packing some suitcases, and I'm taking her home with me. In August, September last year, I brought her to live with me. I had no idea what I was walking into.

I've learned an awful lot in six months. First of all, the trip was very disorienting for her, very hard. She had fallen and broken her arm last July, so she was just going through the therapy and getting back to walking and doing. She was very underweight, very frail. And what's there to taking care of your mom? All you have to do is feed her and take time with her and watch TV with her, okay. And after about the first week or two and mom crying and I'm hysterical because I don't know what to do with this lady that don't know who I am -- she kept calling me Annie. That was her sister. She kept calling me her mother. She kept calling me Toni, and I was like, what's going on here?

So some people suggested I look in the phone book and call the Department of Aging, which I did. That's what this book is. (indicating book) I called the Alzheimer's Association in Princeton, and they in turn sent me a bunch of brochures, and I read a lot of it. I thought, oh, my God, my mom doesn't have all this. She's not this bad, and there again was the denial that my mom-- There's nothing wrong with my mom. She's forgetful. And then she'd say to me, "There's nothing wrong with me." Some people do realize that they have a problem, not my mother. I'm the one with the problem here. And she was always saying this to me. She said, "Okay, well, you forget your keys."

They said short-term memory was gone. Well, sometimes I can't remember what I did last week or where I went or where I spent my money, so maybe I'm already-- No. But anyway, I found out what not having a memory meant. She couldn't tell me what she ate for lunch. At 6:00 in the evening, she'd say, "How come you didn't feed me today," and we had had three meals.

And I would say, “Mom, let’s think what we had today for lunch. Didn’t we have salmon patties or didn’t we have this?” And then she would remember a little bit.

She couldn’t remember where she put anything. Always hunting for her purse. Always hunting for papers. Always hunting-- It was driving me a little bit crazy. Every day was a heartbreak. I’m surprised I didn’t have a nervous breakdown. I think the reason I didn’t was because of the advice I got from the Alzheimer’s Association and because I do work part-time a couple days a week. They suggested adult day care. I got on the phone book, and I found adult day care. And I took my mom out one day to see what they did there. There was a lot of things that impressed me because I don’t want to just put my mom someplace where they’re going to lock her in a cage or something. I didn’t know what to expect because I’ve never faced anything like this. I was very impressed.

Number one, we were there during the exercise class, and my mom loves doing exercise, and I watched the caregivers, and I watched them say to a man in a wheelchair, “Jonathan, come on, do the exercise.” He wasn’t wearing a name badge. They knew his name. They knew everybody and they were loving. And I’m watching the people. They didn’t know I was watching them. Anyway, I said, okay, I can do this. I can take her two days. I’ll get her up every morning 7:00, got her breakfast, got her fed, and-- I don’t know, but when older people get older, and I guess this will happen to me, too, she was always cold. And I never kept my furnace on 80 and 85, but I have for the past several months. And she would dress in layers, three, four, five layers. You know that picture of the Christmas story where the little kid goes out in

the snowman suit, well, that's how my mother would go to the center. And I would go, mom, you're going to be too hot. "No. No. No. I'm cold. I'm cold."

Then I remembered Ronald Reagan. Nancy is taking care of him. I can take care of my mom, but I don't have a staff of a lot of people to help me. And that's when I said, wait a minute, I think I need to get some help here. I don't know how to handle what I'm doing, okay. And I didn't know that I couldn't do 24-hour-a-day care. I had my friends and my family, and thank God I had them because I was, like, reaching the end of my-- I used to get real upset with my brother when his temper was this short with my mom. Then, I found out that mine was shorter. And I said, "God, I need some help."

She was going to the adult day care two days a week, maybe three. But she would go on the bus, and it's a very nice van. She would tell me that she drove for hours and hours and hours and her back hurt. I would go, mom, you're the first one they drop off, I know better. I told her -- I said, no. So I started taking her in the car every morning. I'd get dressed and I'd say, we're going.

I've got to tell you about my Public Service bill for two months. I almost died. I forgot to pay it last month, and it was \$502. She was so cold all the time that she would be turning it up. She was always hiding food, hiding pills. I would try to give her, her medicine, and she was very crafty, she would hide one under her tongue, pretend she swallowed it. When I would go through her room and clean the room, I would find the Tylenol PM, and then I'd say, okay, this is why she didn't sleep the last four nights. This is why she's

been up getting into trouble during the night. This is why she turned the oven on and filled the house with smoke.

I thought I did really good. I childproofed the house, babyproofed it really, took all the knobs off the stove. I have a plate glass stove, you know, the one you just wipe off. She put a crystal glass on it, filled it with juice, and turned it on high. I went out in the kitchen when I heard her humming -- you'll always have to go check on her when she's humming -- she's getting into trouble just like a bad, little kid I learned. I went out there and I said, what are you doing? She said, "I'm heating up my juice." I said, mom, the microwave oven is right here. I had it painted so that she could -- one minute, two minutes, three minutes -- push the knob very simply. She still can't do it, still to this day cannot do it.

Okay, that was the stove. So I said, we're taking all the knobs off the stove because we can't have her getting burnt, dropping the glass, cracking the stove, getting cut. So then she decided that she wanted to make a cup of tea one night. I had gone out to dinner with my friend. I have a girlfriend that has a seven-year-old child, and Terry and I exchange babysitting. She takes care of my five-year-old and I would take care of her seven-year-old.

And this Saturday night I went out for dinner, and I said to Dick, let's go home, I want to make sure mom's okay. I'll put a video in the video, because I had taped some movies that she liked, and I walked in and the house was full of smoke. Terry is standing there crying, and Stacey, and I'm going, "What happened? What's going on?" She decided to make a cup of tea, and she had figured out how to turn my oven on. I didn't know I should take the

knob off of the oven, okay. I had baking pans in there, and I had baking stones, and they had grease in them, naturally, so this grease just--

I had real pretty white curtains. I was telling Leanne on the way up. I should have brought my curtains to show you guys because they kind of look like the chalkboard over there right now. In fact, I started taking them all down yesterday. That was the first time she filled the house with smoke, so I said, okay, we know that we can't have her by herself for an hour, not even half an hour. And in her mind -- I have to tell you what she said to me -- "Well, it's okay, you have house insurance." And I went, oh, no, no, no, no. You just don't rebuild the house, but in her mind, she thinks that's okay.

I took her shopping at Christmastime with my two grandchildren. Michael is 11, Jennifer is 16. I thought we wouldn't have any problems. I left them in Best where it would be very, very exciting for her to walk around, see the computer things, and all this. I went for 10 minutes to pick up something in another store, and I said, I'll be right back. I come back, and they couldn't find her. Everybody in the store was in sheer panic. My daughter said, "Don't you ever do that again. And you can never take the children with you again because they can't watch grandma." She just disappeared that fast. I said, okay, we're not going shopping anymore. Came time for Christmas, I decorated, she never did a thing. This isn't my mother. My mother always did everything. She wanted to bake cookies for everybody that she knew, but she never baked a cookie. I did.

Then Susan said to me, "Why don't you start bringing her to the day care five days a week so that she gets the continuity of doing it every day.

She has to build some regiment here.” So we started that, and that was great. I had to take her to the doctors, and this is a funny story. This is--

I didn't even tell this one to you, Leanne.

She had to do a blood fast, you know, a fast. Did you ever try to keep an 84-year-old lady who likes to eat 24 hours a day not to eat? That was fun.

She wanted a lock on her door because they do -- they have a lot of paranoia, I've learned, about people taking everything from them, stealing from them. So I went to Home Depot and I got a lock. I explained to the man my problem, and he said, "Okay." She didn't want a phone in her room because my phone rings a lot. She didn't want to wake up. So, okay, there was no phone in her room. This morning I'm getting her dressed after a 24-hour fast. She had to be at the doctors at 7:30, and she pushed the door shut, and I don't know how it locked outside, but it did. I got locked in her room and so was she, and there was nobody in the house to get us out. I'm standing there and I thought, what do I do? Well, if the house was on fire, I'd have to get her out. I have to get her out of here.

Obviously, I'm not a little person and my bedroom windows are, and I don't know how I got out. I've had my left leg totally replaced. The right one needed to be done this January, didn't get done. We all know why, I'm taking care of mom. I got out the window, and I had the left leg down hanging on the house. I said, "Mom, push my foot out." It was caught in the track of the window, and I'm going, like, oh, my God, I can't get out of here. I'm stuck. I'm glad Candid Camera was nowhere around. That would have been horrendous. I said, "Mom, push my foot out." She said, "But I'm going

to hurt you.” I said, “If you don’t push it out, you’re really going to hurt me.” I slid down the house, and I got outside and I went, oh, my God, I’m outside, the keys are inside, how do I get in the house. Thank God I had a key outside for the center. The bus driver knew where the key was, so I got back in.

I called my daughter, and I said, “Colleen, you have to take us to the doctors. I don’t think I’m fit to drive because I may kill her and myself or somebody else.” Colleen told me later, she said, “Mom, I’ve only heard you that bad, that upset one other time, and that was the morning you found daddy dead.” And I said, “I know.” So that was my experience with not having a phone in her room. We were going to change all that, so these things would never happen again. My daughter said, “We’re taking the lock off of the door.” And it went off and it never went back on.

Mom loved to dance, and my granddaughter’s birthday was February 6. She turned sweet 16. I said to my girlfriend, “Marge, we’re going to take mom to the church Sunday night to the Widows and Widowers and dance because my mom loves to dance.” So I made a birthday cake for Jennifer. I made a turkey dinner for my girlfriend and everybody -- that we were all going to the dance. Then I took my grandchildren home and we went to the dance, and I forgot to take the knob off of the oven.

Four days later, she decided to make a cup of tea again. And again the house was full of smoke. Unfortunately, she threatened me. She said, “I’m going to have you arrested because you are--” This is my house. Now it became her house, and that’s okay-- And by this time, I’m terribly upset, I’ve only had three hours sleep because I had gotten Terry to babysit. She had given her her pills. We thought she would sleep. It was my first night in six

months to go to Atlantic City to see a show. Saw the show at 8:00, at 12:00 I'm on my way home. I got home about 2:30. Six o'clock in the morning, my house is full of smoke again. By the time I got it kind of like straightened out and I got her back in bed and she's yelling and fighting with me, I was real upset. I went out and took a nerve pill. I never took nerve pills in my life, but I've had to take them for the last six months. I laid down on the bed, and I was crying. I didn't know I could cry anymore. I called 911. In a way it was good and in a way it was bad. I didn't know that they filed reports.

One night my mother called 911. She wanted an ambulance. She has an upset stomach. They called me back. So I didn't know that after three times you get in trouble with 911. We've already two calls. They told me if I had smoke in the house, they had to send fire trucks. I said, "Please, there's no fire. I'll just air the house out." They said, "Ma'am, we have to send a fire truck." They did. I said, "Please, no sirens." My neighbors, 6:00 in the morning, they're going to have a fit. They came in with big fans, and they aired the house and got all the smoke out of the house. I thought, okay, this is the second time. I've got to be more careful with the knobs on the stove. I've got to be more careful.

Two days later, mom and I are watching television. This is on a Monday night. My father, after his house had been destroyed by fire, bought us all a carbon monoxide detector. How many of you in this room have one in your home? (show of hands) Why don't you? It's going to save your life. That's the third time it saved my life. It's only \$50. It's the best \$50 you're ever going to spend. My carbon monoxide detector was screaming like crazy, and I'm going, what is going on? I checked downstairs, I checked the kitchen,

I checked everywhere. Nothing. Nothing. I called Public Service. They said they would come out. They couldn't get there before 11:30. I aired out the house. I got it down to zero. I go back in there, it's up to 18 again. I opened the doors again, got the house aired out again. I go back in, it's up to 19 again. I'm going, what's going on? Now I'm getting scared.

By 11:30 -- I had stayed on zero for two hours -- when Public Service called, I said, "You don't have to come. Whatever it was, it went away." I was a little afraid to go to sleep that night. I have to be honest. In the morning I went to get her up to go to the center, and she said to me, "I can't go. Somebody stole my teeth." I said, "Mom, nobody stole your teeth. They have to be in the room." We started hunting. I called Minda at the center, and I said, "Minda, I can't find her teeth. I'm not going to bring her in." She said, "Rose, we have a lot of people here without teeth, please, you need some space. It sounds like you're having a bad day." And I said, the carbon monoxide, etc. She went, "Get her dressed and bring her out here." And so I did.

And while I was dressing her, I have you show you what I found. This is what the carbon monoxide was trying to tell me -- the detector -- was the lampshade. (displays lampshade with light bulb melted on it) She was always hanging clothes on lampshades. She had put it in here once, and it was burning and smouldering. She went in the room. She saw what it was doing. I didn't. I was in the kitchen or the living room, and she moved it again and now it's here. So she had moved it twice, and this is why the carbon monoxide was saying, "Something's wrong in the house." Well, I was so mad at her because I found it in the corner. She had hid it and covered it up with a towel

just like a bad, little kid. If it was a bad, little kid, you could smack them, put them to bed, or something, but if it's your mother, she'll hit you back. My mom would, too, I know that.

So I take her to the center, and I go home to clean her room and make her bed, and I found a heating pad hot, the plug in the wall hot. How I didn't have a mattress fire, I don't know. I guess her feet were cold. She was clever enough to hide the extension under the-- I don't know how she did this. I couldn't do this. I was so mad I threw it across the wall, and I said, okay, this is four times. I can't take anymore. I was trying to make a square peg fit in a round hole to fit in my life. She can't. She can't. (witness cries) Oh, I'm sorry.

ASSEMBLYWOMAN MURPHY: It's okay.

MS. MAJETICH: Nobody wants to send their mom or dad to a nursing home, at least I didn't. I thought I couldn't. I was saying prayers, and I was saying to my girlfriends, you have to help me pray. I don't know where to turn. I don't know where to turn. Maybe you're luckier if you are solvent, can take care of your parents. I'm not. I'm on a very limited income. If it was not for Hamilton Continuing Health Care, I would not be here today talking, I don't think, because to me this has been a miracle. Peace of mind-wise, I could sleep at night and not have to listen to what she's getting into. They're a very caring group of people. I saw that at the adult day care, but I also saw it when I went up and looked at the nursing home facilities. And I had gone and looked at several, and I was, like, dear God, I really hope that she can be near me, that I can go see her when I can go see her and spend time with her or take her out for the day or do whatever.

They're clean. Ruth was talking about clean. I walked in this morning. They didn't know I was coming. They were cleaning her room. They were taking down the curtains. They were doing everything. I am totally impressed with everything that is there. I can't say enough good things about the place. They're friendly. I walk in-- They have kittens. They have a fish tank. I take my grandchildren to see the fish. They allow her to have her favorite things, like you said, the plants, all these things that mean so much to her.

You have enough guilt and hurt and anger when this happens to your parent. When you realize you can't do it 24 hours a day, somebody has to. The peace of mind that I've gotten-- They treat her with respect. They make sure she eats. I can go in anytime, you're always welcome. I took one mom out to Hamilton Continuing Care Center. When I walk in, I have three or four or five moms following me around. I feel like the Pied Piper. These little ladies are so lonely, and I talk a lot, obviously.

Last night, I took Stacey, my adopted granddaughter with red hair. I should have been aware that they were all going to converge on her. I didn't know this, but all these little ladies came around this beautiful little redhead and were saying how gorgeous she was and what beautiful red hair. I said, "Oh, Stacey, they like you," and we're talking, and she says, "Can I come back to see grandma, can I play with the kittens out in room?" And I said, "Sure, we'll go back anytime."

Stop and see our center. It is wonderful. They will take and make you feel a lot better. I thank you every day for Medicaid and Medicare. When

my husband died suddenly, he kept me from having to go through any of those problems. I didn't know I was going to have them with my mom.

Thank you for listening.

ASSEMBLYWOMAN MURPHY: Thank you for coming here, and I will say just one thing. For your mother to be in a place where people are able to care for her so that she now has a daughter who can visit her with a smile and cheer--

MS. MAJETICH: Yes.

ASSEMBLYWOMAN MURPHY: I just don't think people should ever say, "I never want to put my mother in a nursing home." You placed your mother in a safe, sheltering environment.

MS. MAJETICH: Environment. Oh, it's wonderful.

ASSEMBLYWOMAN MURPHY: And that is a big difference than putting my mother in a nursing home--

MS. MAJETICH: Right.

ASSEMBLYWOMAN MURPHY: --which sounds like I opened a drawer and put her in it and then shut it.

MS. MAJETICH: Absolutely.

ASSEMBLYWOMAN MURPHY: You really didn't. You gave her an opportunity to have--

MS. MAJETICH: I know.

ASSEMBLYWOMAN MURPHY: --a quality of life--

MS. MAJETICH: And now I have a better quality--

ASSEMBLYWOMAN MURPHY: --that she couldn't have at home. And you're able to visit her in a much better frame of mind, which enhances her life--

MS. MAJETICH: Oh, yes.

ASSEMBLYWOMAN MURPHY: --that you couldn't do before.

MS. MAJETICH: Oh, yes. I can go in smiling now--

ASSEMBLYWOMAN MURPHY: That's right.

MS. MAJETICH: --instead of crying all the time.

ASSEMBLYWOMAN MURPHY: That's right.

MS. MAJETICH: I am happy.

ASSEMBLYWOMAN MURPHY: There are nursing homes and their utilization are positive for people who need this and positive for their families. No one size fits all. There is no one situation that we can all fit into, but certainly you've been fortunate. You've found the best one for yourself and for all of your family and particularly for your mother.

MS. MAJETICH: We are totally thankful and very happy.

ASSEMBLYWOMAN MURPHY: Good.

MS. MAJETICH: Thank you.

ASSEMBLYWOMAN MURPHY: Thank you for coming here today. We appreciate it. (applause)

Theresa.

MS. EDELSTEIN: Grace Miller.

GRACE MILLER: I'm nervous.

ASSEMBLYWOMAN MURPHY: Well, don't be.

MS. MILLER: Okay, thanks.

My name is Grace Miller. It's a pleasure to be here today. I'm a certified nursing assistant at the Greenbrook Manor Nursing and Rehabilitation Center, which is a 108-bed, skilled nursing home. I have been employed there for nine years.

Most of the time, my job is very rewarding in doing all the functions of my job duties, especially when resident tells you how much they appreciate what you have done for them. There have been times when a new admission has difficulty adjusting to their new home, and many times it takes several weeks or even months before you build a confidence and a relationship with them. It is very satisfying once this happens.

Greenbrook Manor to me is like home away from home. Each staff member is like family. We take care of each other by assisting each other when needed, as well as give quality care to the residents in a serious environment where today, tomorrow, or maybe later it may be the resident's last days. We try to have fun with the residents and have them enjoy their day, as well as let the resident have peace of mind that they are loved.

The most difficult part of my job is trying to help families adjust to placing their loved one in a nursing home. We appreciate the families input, but sometimes they do not realize that a nursing aide has gone through a 90-hour course and have been trained to use proper care procedures. There are many times that if the families would let us do the care we were trained for, it would be easier for the (indiscernible) and also more comfortable for the residents. At Greenbrook Manor, we are assigned to the same resident on a full-time basis, and we really do get to know the residents very well. I feel if

the family members would realize this, it would make it easier for all concerned.

I am very proud to be a certified nursing assistant, and I am proud to work at Greenbrook Manor. Please stop in and visit us, our staff, residents, if you get a chance.

Thank you.

ASSEMBLYWOMAN MURPHY: Thank you very much. You did beautiful. (applause)

MS. MILLER: Thanks. Thank you.

ASSEMBLYWOMAN MURPHY: If there are any questions of any of the presenters this morning, we'd be happy to entertain them at this time? (no response)

If not, I will speak with the members a little bit about dates.

Peggy, do you have any--

Oh, Medicaid. Oh, my goodness. Thank you. My goodness.

We have staff from the Department of Health and Human Services, Marlene Verniero. Where is she? (affirmative response from audience)

There you are. I didn't even see you in the back. Come on up, Marlene. Talk to us about Medicaid.

ASSEMBLYMAN ROMANO: While she's coming up, that lady with the blonde hair. I'm sorry, I don't recall your name. Who's paying for your mother in the nursing home?

MS. MAJETICH: (speaking from audience) Medicaid and Medicare.

ASSEMBLYMAN ROMANO: Medicaid and Medicare.

ASSEMBLYWOMAN MURPHY: Hi, Marlene.

MARLENE VERNIERO: Good morning, everyone. I'm Marlene Verniero, the Director of the Office of Waiver and Program Administration in the Department of Health and Senior Services. Rich Hruby is here today. Thank you for having us, Madam Chairperson and members of the Council. If it's okay with you, I'm here really to speak about two unique Medicaid programs -- the Medicaid Waiver Program, the assisted living, alternate family care waiver, and the Community Care Program for the Elderly and Disabled.

We thought it would be helpful if we would start off with a general -- what is Medicaid, and a little bit about the eligibility because we felt that that would be helpful. I'll have Rich do that for a few minutes, and then I'll come back.

Is that okay?

ASSEMBLYWOMAN MURPHY: Okay. Don't go far.

MS. VERNIERO: Okay.

ASSEMBLYWOMAN MURPHY: Don't sit in the corner again. I didn't even see you there.

RICHARD HRUBY: Good morning.

ASSEMBLYWOMAN MURPHY: Good morning, Rich.

MR. HRUBY: This is not going to be the end-all or be-all of the Medicaid eligibility. It's a terribly complex issue. This is going to be Medicaid Eligibility 101. There's a handout. When the print is fairly large, as you might suspect, though, the devil is in small print, which-- And I'm prepared to answer any questions relating to the small print that you might have.

The fundamental basis of Medicaid eligibility overall and as it applies to the aged, blind, and disabled in particular is a welfare basis, or the SSI Program rules a lot of the criteria. So when it comes to income, for instance, we apply the same disregards that apply in the SSI Program.

ASSEMBLYWOMAN MURPHY: Disregards?

MR. HRUBY: Excuse me?

ASSEMBLYWOMAN MURPHY: Disregards. What does that word mean?

MR. HRUBY: It's a term of art. Sorry. In comparing an individual's income to the income cutoffs for the program -- the various income cutoffs, we disregard certain amounts of income. When it comes to an aged, blind, or disabled individual, most often it is simply that first disregard, the \$20 general disregard; we rarely have instances of earned income.

ASSEMBLYWOMAN MURPHY: Now, what does \$20 general disregard mean? Twenty dollars from what?

MR. HRUBY: If the individual's income is \$600, we will reduce it to \$580 in comparing it to the figure. It's just an arbitrary-- Again it's a welfare-related disregard that applies also in the Medical Assistance Program.

ASSEMBLYWOMAN MURPHY: And that is a Federal--

MR. HRUBY: That's right. It's Federal.

ASSEMBLYWOMAN MURPHY: --number.

MR. HRUBY: Yes.

ASSEMBLYWOMAN MURPHY: Okay.

MR. HRUBY: And actually that number is the same as it was in the very beginning of the SSI Program when it was established in 1971. It has never been modified.

ASSEMBLYWOMAN MURPHY: It doesn't seem to have much bearing on the real world, \$20 dollars.

MR. HRUBY: No, it doesn't.

On the second page of the handout, you can see--

ASSEMBLYMAN THOMPSON: Before we leave that--

MR. HRUBY: Sure.

ASSEMBLYMAN THOMPSON: As you said, \$600, is that monthly or is that weekly?

MR. HRUBY: Monthly. And the disregard also applies monthly.

On the second page of the handout, you can see the income standards that are employed in the Medicaid Program.

ASSEMBLYWOMAN MURPHY: Now, just let me go back to the first page. We've taken care of the \$20 -- is just a figure established. Sixty-five dollars and a half of the remainder, what does that mean?

MR. HRUBY: That is very rarely used earned income disregard mostly for individuals who still reside in the community. Frequently, disabled individuals might have some earned income, and that's a fairly generous tax rate, you might call it, that would reduce their earned income when we compare it to the income standards.

ASSEMBLYWOMAN MURPHY: So you've taken the 20 off, I'm down to 580. Now you're going to take off \$65?

MR. HRUBY: Right.

ASSEMBLYWOMAN MURPHY: And then you're going to take half of the remainder?

MR. HRUBY: Right. So roughly, in that case, roughly only \$260 would count.

ASSEMBLYWOMAN MURPHY: Is considered earned income?

MR. HRUBY: That's right.

ASSEMBLYWOMAN MURPHY: Okay. So \$260, I would be eligible.

MR. HRUBY: That's right.

ASSEMBLYWOMAN MURPHY: Okay. Thank you.

MR. HRUBY: On the second page, that first table is the figures by which most people become eligible among the aged, blind, and disabled for Medicaid. These are what they call SSI living arrangements. Again the whole basis of the program is an SSI structure. So an individual living in the community by his or herself, the income standard is \$531.25.

ASSEMBLYWOMAN MURPHY: Okay.

MR. HRUBY: Again, because of that \$20 disregard, the actual -- they could have income up to \$551.25.

ASSEMBLYMAN THOMPSON: And what does resources mean? In the bank or something?

MR. HRUBY: Resources are what you would normally consider to be assets. It would be monies in the bank, stocks, bonds.

ASSEMBLYWOMAN MURPHY: It wouldn't just be 551. It would be 551-- I could have \$65 more than that also, couldn't I? And half that income again?

MR. HRUBY: That 65 and one-half applies only if you have earned income, and again that's fairly infrequent.

ASSEMBLYWOMAN MURPHY: Oh, okay. Okay.

MR. HRUBY: Because there's another rule that also applies to the aged, blind, and disabled. And that is, if you have activities of life that are like work activities, for instance, a disabled individual, they are assessed as having what they call substantial gainful activity, which then can affect their disability status.

ASSEMBLYWOMAN MURPHY: What does that mean, that kind of activity? Can you define that? An example?

MR. HRUBY: It would be work-like activity, whether it would be a volunteer at a hospital or, in fact, actual employment of -- over a period of six months, and Social Security Administration would reevaluate the disability status. And so, if you're working, there's a good chance you could lose--

ASSEMBLYWOMAN MURPHY: So if I'm well enough to be a volunteer, I probably shouldn't get disability.

MR. HRUBY: That's correct.

ASSEMBLYWOMAN MURPHY: Okay.

MR. HRUBY: But that does not apply to persons over the age of 65. That criteria is not employed.

ASSEMBLYWOMAN MURPHY: Okay.

MR. HRUBY: Again, this first chart is illustrative of how most people attain eligibility in the community. But the bottom figure, what we call Title XIX Institution Medicaid, the \$1500 a month figure, that's what we call the Medicaid cap, and that's how most people qualify in a nursing facility.

ASSEMBLYWOMAN MURPHY: Now they can have up to \$1500 a month and they still qualify for a nursing facility.

MR. HRUBY: That's correct. That was until about five years ago the absolute cutoff for Medicaid eligibility in a nursing facility.

ASSEMBLYWOMAN MURPHY: Correct.

MR. HRUBY: About five years ago, the Legislature passed a bill that authorized medically needy coverage for nursing facility services. And so now that's a subsequent chart that ends the really complicated form of eligibility, but it really boils down to, if an individual's income is less than the cost of their care in a nursing facility, they can obtain Medicaid eligibility.

ASSEMBLYMAN ROMANO: What's RHCF, please?

MR. HRUBY: Residential health-care facility.

ASSEMBLYWOMAN MURPHY: If my income is less than the care than it costs me to be in a facility with care, then I am still eligible for Medicaid?

MR. HRUBY: That's correct.

ASSEMBLYWOMAN MURPHY: And I can choose any facility, or is it the cost of services? Because I know a not-for-profit facility has to actually cost out their services; they are not reimbursed at a profit level. They are reimbursed at the cost of their services on a median, right?

MR. HRUBY: That's right.

ASSEMBLYWOMAN MURPHY: Okay.

MR. HRUBY: It would be the cost of the facility in which you reside. Usually, this is not a difficult process. The individual has \$2200 income. Generally, it's assumed that they are going to be eligible. The county

welfare agency would, in fact, look at the charges, though, of that facility to make sure that the eligibility exists.

ASSEMBLYWOMAN MURPHY: Okay.

MR. HRUBY: Yes.

MS. MICHELSEN: Rich, I think you should clarify that the-- This doesn't mean the person can keep \$1500 disposal income to do what he or she wishes--

MR. HRUBY: That's right.

MS. MICHELSEN: --if that \$1500 is contributed to the cost of the nursing care.

MR. HRUBY: That's right.

ASSEMBLYWOMAN MURPHY: Correct. No. I did understand it.

MS. MICHELSEN: Right. But I don't know if everybody knows that.

ASSEMBLYWOMAN MURPHY: Thank you. I appreciate that, though, Renee. It's a good reminder.

MR. HRUBY: One of the reasons I produced it is I guess, to give you an appreciation of these charts -- is that the actual eligibility determination might seem simple on the surface because people are eligible if their income is less than the cost of care.

There are so many different ways, federally, that we have to put them in the right bucket for reporting purposes that actually, at the county level, the determination is a little bit more difficult. The one thing you will take note of is the resource, or asset, test for the regular SSI Medicaid only

groups for an individual. The asset limit is \$2000, and that's not much money.

ASSEMBLYWOMAN MURPHY: Right.

MR. HRUBY: On the second table, which is New Jersey Care eligibility, which is related to the Federal poverty level, the resource, or asset, test is \$4000. So it creates an anomaly that if an individual's income is below poverty, they can retain \$2000 in resources. Excuse me, below poverty they retain \$4000. If their income is above poverty, they can only retain \$2000.

ASSEMBLYWOMAN MURPHY: And why is that?

MR. HRUBY: I suppose I would blame sort of the Congress in doing sort of patchwork revisions to the Medicaid statute. They sort of do, like, what feels good at the moment, and they said, "Well, the state can have an asset limit up to \$4000." The State, in fact, adopted the most liberal asset test that we could, but then it creates this anomaly or confusion. Likewise with the medically needy program, the asset limit is also \$4000. So if your income is above poverty but below 1500, you can only retain 2000. But if it's above 1500, you can retain 4000. This is one of the things that a lot seniors and their families get very puzzled about.

ASSEMBLYWOMAN MURPHY: I can understand why.

ASSEMBLYMAN ROMANO: What is this, "New Jersey Care (100% of Poverty)?" (referring to chart) I mean, where does that come into this whole matrix in Medicaid? Medicaid and SSI are the top-- What is the purpose of this New Jersey Care business?

MR. HRUBY: That was an enhancement to the Medicaid Program that Congress made available a number of years ago. It, in fact,

slightly expanded the window of eligibility for people in the community. It really didn't change eligibility in nursing facilities, except that it's another determination the county has to make to put the individual in the right bucket for Federal reporting purposes.

ASSEMBLYMAN ROMANO: Is it still in existence?

MR. HRUBY: Yes, it is.

The number, by the way, there -- the Federal government has not yet published this year's poverty guidelines, and so, the number there is a 1998 figure. Generally, the Federal government has it out by now, but we don't yet have it.

ASSEMBLYMAN THOMPSON: You also have couple data and eligible couple data. So if there's a husband and wife and one of them needs to go into a nursing home, then say, even though the other one's not going, the couple could only have a combined income of \$905 and resources of 6000?

ASSISTANT COMMISSIONER READER: For New Jersey Care.

MR. HRUBY: That standard would apply in the community were they both going into the same nursing facility.

ASSEMBLYMAN THOMPSON: But I'm saying where only one is going into the facility--

MR. HRUBY: Okay.

ASSEMBLYMAN THOMPSON: --and the other one is not going into the facility and, therefore, is hoping to live in their home.

MR. HRUBY: Okay. I'm sorry.

ASSEMBLYMAN THOMPSON: Do these restrictions apply relative to the combined income of the two even though one's not going into the facility or--

MR. HRUBY: If one member of the couple is going into the facility, then we look at his or her income, separate and apart.

ASSEMBLYMAN THOMPSON: And resources-- For example, thus, they own a house. Does that impact it?

MR. HRUBY: The house would not be a countable asset so long as the spouse remaining in the community continues to reside.

ASSEMBLYMAN THOMPSON: Okay.

MR. HRUBY: But resources is an exception. We do look at the combined resources of the couple under a provision that's called spousal impoverishment, which you probably have heard of, and I'll touch on that in a moment.

ASSEMBLYMAN THOMPSON: I think that was something that was controversial recently.

MR. HRUBY: Yes.

ASSEMBLYMAN THOMPSON: But in that case, it does not consider the house. It is exempted.

MR. HRUBY: That's correct.

DR. HEATH: But other noncash resources are included?

MR. HRUBY: Yes.

DR. HEATH: Resources doesn't just refer to cash resources?

MR. HRUBY: That's correct. It would be anything that can be liquidated essentially, whether it be a boat or stocks or bonds or what have you.

Let me touch first with single individuals because that's predominantly what we face in the eligibility world. Only 11 percent or 12 percent of persons going into nursing facilities are married, so the most common thing that the county welfare agency is dealing with is a single individual.

ASSEMBLYMAN THOMPSON: But you also indicated if only one partner of a couple is going in, that person is treated as a single individual, right?

MR. HRUBY: For income purposes, not for resource purposes. Let me just deal with the single individual first.

ASSEMBLYMAN THOMPSON: Okay.

MR. HRUBY: They're allowed to retain either \$2000 or \$4000 in countable assets for their own use, but virtually everything else would be counted as an asset. Their automobiles, since they're no longer going to use their automobile, would be a countable asset. We look at the cash surrender value, for instance, of life insurance as something that a lot of people don't think of as an asset, but, in fact, if the face value of the life insurance is over \$1500, we will count the cash surrender value of that policy.

What is now, and this has not always been, but what is now an exemplary source for the most part are burial funds. It used to be if people had money set aside for burial, even a modest amount, we would count that toward their eligibility. There was a revision to State law about four or five years ago

that provided that certain burial accounts could be exempt for Medicaid purposes.

MS. MICHELSEN: In any amount?

MR. HRUBY: In any amount.

ASSEMBLYMAN ROMANO: For the rest of my colleagues, I'm sure the Chairperson will share, this is a subject of a bill in terms of going back to the State what is left over, rather than to go to the estate.

MR. HRUBY: That's right.

ASSEMBLYMAN ROMANO: And you'll notice that I think all the undertakers, funeral directors, are in favor of it because this was Part *B* because Part *A* was to put a max on how much you could have in that account, which would, in effect, control how much someone could pay for a funeral. So this is the second option. That deserves, and not here -- that deserves a long conversation because I happen to have a personal view on it. If someone has, let's say, \$1000 left over after, they're saying, "Well, that money originally originated from money given under a Federal or State program." Is that the case? I mean, are we stretching this whole definition a little bit here in terms of whose money that belongs to? Is it the State's, or is it personal? I'm not talking on behalf of heirs, but just in the matter of -- let's not say that this money here that's left over is only the State's money or the Federal money. So I'll move off that now, but that's the consideration.

ASSEMBLYMAN THOMPSON: Didn't we pass that--

ASSEMBLYMAN ROMANO: No, we didn't. I think they held the bill.

ASSEMBLYWOMAN MURPHY: Let's finish on this. It's driving me nuts.

ASSEMBLYMAN ROMANO: But I have to just tell you something. I've learned in this business and even when I was a business administrator never to become the resource to explain all this. There's always the proper agency. This is for reference only because the last thing-- What would happen if you gave somebody the wrong information?

ASSEMBLYWOMAN MURPHY: Right.

ASSEMBLYMAN ROMANO: So the person in the State or Fed, if we're talking, are the specialists. You refer to them. This is only for a guide.

MR. HRUBY: That's correct.

MR. HRUBY: You're going to say, "I think you're going to be eligible." I wouldn't attempt to say who's eligible and who's ineligible in the case of one of these things here.

ASSEMBLYWOMAN MURPHY: Right.

MR. HRUBY: There are many times when I wish I--

ASSEMBLYMAN ROMANO: They change constantly.

MR. HRUBY: I wish I had taken your advice about not becoming a resource. (laughter)

ASSEMBLYWOMAN MURPHY: Too late. Okay.

MR. HRUBY: Particularly if I'm driving the Chair nuts. (laughter)

ASSEMBLYWOMAN MURPHY: No. It's just my inability to sometimes understand these things, but anyway.

MR. HRUBY: Again, then, with a single individual, since in most cases there is nobody occupying the home in the community, that home is subject to a plan of liquidation. The individual needs only to agree to the plan of liquidation prior to establishment of Medicaid eligibility, but, in fact, the individual and/or family must, in fact, liquidate the home in six months with a three-month extension available.

ASSEMBLYMAN ROMANO: Let's not play with that one. You just said-- What happens when you have a spouse still remaining in the home?

ASSEMBLYWOMAN MURPHY: No, they said they stay.

ASSEMBLYMAN ROMANO: That's my impression, but what you were saying has me confused.

ASSEMBLYWOMAN MURPHY: No. No.

MR. HRUBY: The house will continue not to be counted if, in fact, it's occupied--

ASSEMBLYWOMAN MURPHY: Right.

MR. HRUBY: --by a spouse or any other dependent relatives -- a disabled child or whatever.

ASSEMBLYMAN ROMANO: Have you found the State to be vigorous or aggressive in getting back that money when someone dies? Or has it been a matter of-- I don't even know if they're going to get after you for the money but--

MR. HRUBY: I guess New Jersey's policy is somewhat unique as far as requiring the liquidations of homes prior to establishment of Medicaid eligibility or during Medicaid eligibility. So with an awful lot of individuals, the home is the most valued asset they have. And, in fact, if that's liquidated

prior to death, there is very little left in the estate generally. I used to work with the individuals involved. I believe they are fairly vigorous in going after what does, in fact, remain. But again the allowable asset limit is \$2000. There's not often much of an asset for them to go after.

Upon the sale of the house, the individual has a choice. They can either reimburse the State for the Medicaid expenditures that the State has already made, or, and I think it's more commonly chosen, they just use those assets to pay privately until such time as they might qualify again for Medicaid.

ASSEMBLYWOMAN MURPHY: Okay.

MS. MICHELSEN: So they use Medicaid until they sell the house.

MR. HRUBY: That's right.

MS. MICHELSEN: So they can get the care right away. And then once the house is sold, they go off Medicaid until they exhaust those funds.

MR. HRUBY: Exactly. It serves sort of as a bridge because at the time a person needs to go into a nursing facility, it's often immediate, and if we were to count the house as a prohibiting factor--

ASSEMBLYWOMAN MURPHY: They wouldn't get in.

MR. HRUBY: --entry would be precluded.

When it comes to a married couple, one of whom needs to go into a nursing facility, there is the misnomer -- the Federal misnomer -- of spousal impoverishment. What this was, was actually designed to make sure that the individual who remains in the community has enough assets to maintain some level of lifestyle. The way that the amount that's protected for the community

spouse is established is we take a snapshot of all the assets -- countable assets -- of the couple at the time nursing home care is required. The community spouse gets to keep the greater of \$16,392 or one-half of the assets, not to exceed 81,000 and change.

ASSEMBLYMAN THOMPSON: There was a case that got a lot of publicity recently--

MR. HRUBY: That's right.

ASSEMBLYMAN THOMPSON: --and I think that will add to the introduction of the bill, which is currently in, which would change our maximum to coincide with the Federal maximum, as I recall--

ASSEMBLYWOMAN MURPHY: Which is?

ASSEMBLYMAN THOMPSON: --which tends to say that ours currently is lower than the Federal allowable.

MR. HRUBY: Ours is what would be called the Federal minimum, as far as the set aside for the community spouse. The Federal government says that the State can authorize the first \$81,960 to be set aside for the community spouse, but we the bureaucracy, lacking State statute at the time we implemented that provision, we went to the Federal minimum.

ASSEMBLYWOMAN MURPHY: And what is the bill changing it to -- higher than the 81 amount?

ASSEMBLYMAN THOMPSON: The bill is changing it to the Federal maximum, I'd say, as opposed to the Federal minimum.

MR. HRUBY: Yes.

ASSEMBLYWOMAN MURPHY: And what is the Federal maximum?

MR. HRUBY: Rather than applying this formula of the greater of and one-half, the first \$81,960 would be protected for the community spouse's use.

ASSEMBLYWOMAN MURPHY: Oh, okay. I got it.

ASSEMBLYMAN ROMANO: The real intention to our meetings. It said that this is not, as years ago, they thought of 50/50 on the house. They used to figure 50 percent/50 percent. There was a case, that's what Sam was referring to--

ASSEMBLYMAN THOMPSON: But a certain part of the house is not included in that.

ASSEMBLYMAN ROMANO: --where the husband's responsibility in that case or where the two were in ownership goes beyond 50 percent that that spouse has an obligation with that spouse's own money or shares to pay off part of the debt of this spouse. You follow what I'm saying? When they used to work before, it was a house was worth \$200,000: \$100,000 was the wife, \$100,000 was the husband.

ASSEMBLYWOMAN MURPHY: Right.

ASSEMBLYMAN ROMANO: And then when he sells the house after she dies, etc., the State share of that was hers, which was 100,000. No, it doesn't work that way. It's now going to be that the State would get \$125,000 because we round out how much they're saying you can keep. You can only keep at 75,000 or 80,000, whatever it is. You'll notice you lost 25,000 in that whole mechanism, that the State enjoys that 25,000.

ASSEMBLYMAN THOMPSON: But I think you said earlier the house was not included in the resource material in this case.

MR. HRUBY: That's correct. In fact, the house is not part of that calculation. If they have a \$200,000 house and they have \$80,000 in assets, we will not count the \$200,000, and we would protect \$40,000 for the community spouse in addition to the house.

ASSEMBLYMAN THOMPSON: The spouse keeps the house without--

ASSEMBLYMAN ROMANO: No. No. No. I'm not talking the spouse keeping--

ASSEMBLYWOMAN MURPHY: The same when the spouse dies.

ASSEMBLYMAN ROMANO: When the two of them have-- When the spouse dies and he wanted to liquidate that, he's selling the house, okay, he's going to put himself into a nursing home, my understanding is it's no longer 50/50. He cannot walk away with more than 76,000 or 82,000 or 83,000, or what you're talking about here.

MR. HRUBY: I would have to explore that. I'm not quite familiar with that.

ASSEMBLYMAN ROMANO: Yes. Explore it.

ASSEMBLYMAN THOMPSON: I thought he was saying the house is not included at all. You don't have to worry about it if you have one spouse--

MR. HRUBY: Generally, that's true.

ASSEMBLYWOMAN MURPHY: But that's to live in it until he is--

ASSEMBLYMAN THOMPSON: Oh. Is it only to live in it, or does that apply when he sells it, too? That's what I'm trying to clarify.

MR. HRUBY: Well, it's automatically excluded if it's occupied by the community spouse.

ASSEMBLYWOMAN MURPHY: Right.

ASSEMBLYMAN THOMPSON: And if he sells it at some point?

ASSEMBLYWOMAN MURPHY: But when the community spouse dies, if the other spouse is dead, what happens to the proceeds from the house?

MR. MUNIZ: It's the estates.

MR. HRUBY: It would be part of the estate presumably. If it was jointly held, it presumably would be perhaps part of both.

ASSEMBLYMAN THOMPSON: We're saying the one in the nursing home dies.

MR. HRUBY: Yes.

ASSEMBLYMAN THOMPSON: If the one in the nursing home dies, then later, okay, the other guy has the whole house now.

MR. HRUBY: Yes. And that's where the estate recoveries would come in. They would not put a lien on the house until the death of the community spouse, but, in fact, then the State would take a percentage of it.

ASSEMBLYMAN THOMPSON: But at that point, they would take it. Okay. I understand.

ASSEMBLYWOMAN MURPHY: Right. And should because that's paying back all the taxpayers in the state for the support of that spouse in the nursing facility all that time.

MR. HRUBY: That's right.

ASSEMBLYWOMAN MURPHY: It usually wouldn't cover the cost of it, but it's part of putting it back in for someone else to use. Okay.

MR. HRUBY: Yes. But just so you know, under the Federal law, the spouse going into the nursing facility can transfer his ownership rights to that house to the community spouse legally. And thereupon the death of the individual in the nursing facility, it's not part of his estate any longer. He has no ownership interest.

ASSEMBLYWOMAN MURPHY: Therefore, not avoid putting any money--

ASSEMBLYMAN ROMANO: I didn't want to touch this one then. If this is done within three years of going into the nursing home, aren't there -- How can I put it? -- criminal limits or -- What would the right term be, Sam? -- charges?

ASSEMBLYWOMAN MURPHY: Yes. I would think.

ASSEMBLYMAN ROMANO: You have three years. If you do it within three years, you have to make this known.

MR. MUNIZ: Thirty-six months. Yes.

MR. HRUBY: Yes. Let me touch on that. Just so you know, the transfer between spouses--

ASSEMBLYWOMAN MURPHY: Correct.

MR. HRUBY: --is not subject to any of the penalties involved with resource transfer.

ASSEMBLYWOMAN MURPHY: And they can be made at any time?

MR. HRUBY: Yes.

ASSEMBLYWOMAN MURPHY: Okay.

MR. HRUBY: What you're referring to is a presumption of -- that the State makes that if an asset has been transferred within 36 months of application for Medicaid for long-term care services, the presumption is you did that to qualify.

ASSEMBLYWOMAN MURPHY: Yes.

MR. HRUBY: And the way we do that is we divide the asset transferred by a figure that's currently \$3376. The resulting whole number is the number of months of ineligibility for long-term care services from the date of transfer. So if you transferred \$100,000 to your son, there's going to be a penalty of roughly 28 months of ineligibility. But if you did it 28 months prior to requiring long-term care, there is no penalty.

There is, I guess it was about three years ago, a criminal aspect to the transfer, and I believe it reads that anybody who advises or counsels an individual to transfer an asset is guilty of criminal conduct. And I forget what the punishment is supposed to be.

ASSEMBLYWOMAN MURPHY: How about all the lawyers that do all this great estate planning?

MR. HRUBY: Well, for a little while they got terribly nervous.
(laughter)

ASSEMBLYWOMAN MURPHY: They went out and hired lawyers. (laughter)

MR. HRUBY: But Janet Reno announced over a year ago that the Federal government would, in fact, not be prosecuting attorneys for giving legal counsel. She didn't deem it to be constitutional.

ASSEMBLYWOMAN MURPHY: Oh, now we know who's giving legal advice. Okay.

MR. HRUBY: The other thing that was touched on was the fact that the income that we look at in the eligibility determination then is used by the State for the cost of care. In general, a single individual gets to retain \$35 in personal needs allowance a month. And in general, the remainder of their income then is applied to the cost of care. In the case of a married individual, they get that same \$35 personal needs allowance, and then we look at the community spouse's income to see if, in fact, some of that income of the institutionalized individual should be applied to her needs. And so, what we do is we take enough money to raise her community income to a level of \$1357 a month, and there's also some consideration if she has high shelter costs. It can be a higher level.

ASSEMBLYWOMAN MURPHY: Okay.

MR. HRUBY: I've also given you a list of the services available under the Medicaid Program. The two-columned one (indicating handout) is the regular Medicaid Program, and you'll see that that's a fairly universal coverage of virtually everything. A lot of the things in this list don't apply to the aged, blind, and disabled individuals necessarily. The shorter page are the restrictions of services under the medically needy program. Most significant for the aged, blind, and the disabled is the medically needy program does not cover inpatient hospital care.

I think part of the presumption in making that distinction was that most aged, blind, and disabled individuals have Medicare and that is wasn't going to be a critical issue. And plus, uncompensated or charity care would cover the rest as well.

Do you have any other questions?

DR. HEATH: Do you have insider or impressions of how New Jersey's eligibility thresholds compare with both neighboring states, as well as national standards? In particular, neighboring Pennsylvania and New York.

MR. HRUBY: It's sort of a madras. It's difficult to say one state is particularly more generous or whatever than another. New York State, for instance, is already at that maximum on protecting the assets for the community spouse. I believe Pennsylvania does it the same way we do it. Since New Jersey adopted the medically needy coverage for long-term care, we joined the 21 other states that, in fact, did cover above that \$1500 cap. And so in those 22 states, people are eligible so long as their income is below the cost of their long-term care.

MR. MUNIZ: I need clarification. If you had a couple that has \$100,000 in assets, one of them is going to the nursing home -- that person, the one that stays in the community, is entitled to \$50,000 of that 100,000. Let's say the person dies in the nursing home and then the person that's in the community also dies, where's that \$50,000 go to? Does that go to the estate of the person, or does the Department of the State of New Jersey attempt to recoup some of that money?

MR. HRUBY: At least as I understood your example, the State would have no right to that money because eligibility had not been established

yet. When we look at the case, we say \$50,000 is protected for the community spouse, but now there's another \$50,000. You're not eligible until that \$50,000 is reduced to 2000, so the expectation is that you would pay privately until that 50,000 was expended.

MR. MUNIZ: Okay. Got it.

ASSEMBLYWOMAN MURPHY: Okay. Thank you.

MR. HRUBY: Thank you.

ASSEMBLYWOMAN MURPHY: I don't know that they're all the questions I will have, but they're all I can think of at the moment.
(laughter)

Thanks, Rich, very much.

MS. VERNIERO: Okay, for those states that are participating in Medicaid, and that's virtually all of them, the Federal Health Care Financing Administration allows states to develop home- and community-based alternatives to institutional settings. Those unique programs are referred to as Medicaid waivers. In the State of New Jersey, we have nine such waivers. Two of the nine are primarily focused on serving the elderly and came to the Department of Health and Senior Services to administer with the consolidation.

The first Medicaid waiver that I'm speaking of today is called the Community Care Program for the Elderly and Disabled, known as CCPED. It's a very popular program. It's been in this state since 1983 and currently serves about 3300 folks throughout the state. To be eligible for CCPED which, in fact, allows individuals to remain in their own home, an individual must be age 65 or older, or disabled regardless of age, with a monthly income of greater

than 531.25, which was the SSI level that Rich was talking about earlier, but less than 1500 monthly income with \$2000 or less in assets. So that's the Medicaid eligibility.

For CCPED, an individual must have health-care insurance -- I handed out fact sheets to this effect, too, so you don't really have to take too many notes -- and the person must be clinically assessed as needing nursing facility level of care. So there's two eligibility criteria essentially: one is the financial eligibility of Medicaid, and the other is clinical eligibility stating that the individual, if this program did not exist, would otherwise be in a nursing facility or needing an institutional setting.

The services offered for folks on CCPED are case management, home health, homemaker, medical day care, nonemergency transportation, respite care, social day care, and prescribed drugs. Only those eight services are available with CCPED. The folks currently being served by CCPED have a very high level of need. We're averaging, currently, folks needing assistance with daily living of four activities: grooming, eating, bathing, mobility, dressing. Four -- the average is four, so individuals staying in their own home really have a great need, and we are really keeping them in their own home with high levels of frailty.

The second waiver--

ASSEMBLYWOMAN MURPHY: Before you move off CCPED, they are eligible to receive this, they receive this, and they do not have to pay. They are paid for by the State, the CCPED time or services?

MS. VERNIERO: Yes. There is no cost share liability for individuals on CCPED; however, they do pay for their own health-care insurance.

ASSEMBLYWOMAN MURPHY: And how many hours a week do they have of this service?

MS. VERNIERO: I can give you an average. Currently, the -- we refer to them as waiver slots -- 80 percent of the individuals on CCPED are allowed to spend up to \$1989 a month for services. So Medicaid will reimburse up to that cost cap. That translates to about 20 hours of home health a month.

ASSEMBLYMAN ROMANO: Do you want to rephrase that?

MS. VERNIERO: Sure. Medicaid allows for approximately -- reimbursement for CCPED clients -- about \$14,000 a year.

ASSEMBLYMAN ROMANO: Okay.

MS. VERNIERO: Okay. As compared to 35,000 for a nursing facility, okay. And we also have 20 percent of the individuals, depending on their need, we can spend up to \$2841 a month. So as they age in place in their own home, as they get more frail, we can increase the spending for CCPED and still allow them to stay in their own home up to almost \$3000 a month.

ASSEMBLYWOMAN MURPHY: Twenty hours per month, that's five hours a week plus a month.

ASSEMBLYMAN ROMANO: Five hours a day, four days a -- wait a minute. No.

ASSEMBLYWOMAN MURPHY: Twenty hours a month, that's five hours a week in a four-week month.

MS. VERNIERO: Is that wrong? Is it 20--

MS. MICHELSEN: It's up to 24 hours a week, isn't it? That's what I thought.

ASSEMBLYMAN THOMPSON: Well, what she's saying were the averages, though.

MS. VERNIERO: I'm sorry. That's a weekly. It's a 20-30. I'm sorry. It's a weekly, not monthly. It's 20 or 30 hours.

ASSEMBLYWOMAN MURPHY: Okay.

MS. VERNIERO: So if it averages 20 hours a week-- It averages about \$14 an hour. That's the average, \$14 a hour.

ASSEMBLYWOMAN MURPHY: So they can have anywhere from 20 to 30 hours a week depending on the severity of the--

MS. VERNIERO: Yes. I'm sorry. My mistake.

ASSEMBLYWOMAN MURPHY: That's okay.

ASSEMBLYMAN THOMPSON: Actually, wouldn't it be more, like, from 10 to 30? That is, some would have less, if that's the average. Some would have less.

MS. VERNIERO: Well, yes. Most folks -- and the care managers who authorize services, they have their rule of thumb. They call it 20-30. But really, in actuality, there's eight services that an individual can have. Many of the services are focused around the homemaker or home health, but it could be medical day care, which is \$55 a day, or social day care, which is \$30 a day, or it could be something else at a lesser cost. But the primary focus, if you look at a care plan, much of it has to do with the homemaker.

ASSEMBLYMAN THOMPSON: Is this the program that there was considerable row over last year that the Feds were cutting back in a number of states that were doing a pretty good job, including New Jersey, while allowing more in other states that were abusing the system?

MS. VERNIERO: No. This is a unique program specifically--

ASSEMBLYMAN THOMPSON: I thought there was some cutback on the hours for home health care?

MS. VERNIERO: Maybe home health services in general.

ASSEMBLYMAN THOMPSON: Okay, so that's separate.

MS. VERNIERO: Home health is one of the services available to the CCPED beneficiaries.

MR. MUNIZ: How many people are taking advantage of this program?

MS. VERNIERO: Currently, we are allowed to have at any one time 3300 people served.

ASSEMBLYMAN ROMANO: Don't they put money in?

ASSEMBLYWOMAN MURPHY: Who?

ASSEMBLYMAN ROMANO: The persons.

DR. HEATH: Did I understand you to say that the longer you're in, the higher your cap goes?

MS. VERNIERO: No. We are allowed to-- Generally, folks begin services with a cost cap of 1989, but if they need more services, we do have some flexibility within the program to increase their spending up to 2841 to still enable them to stay home. So if they can still be maintained in the

community and really don't really need to be institutionalized, we do have some flexibility with the spending.

MS. MICHELSEN: That's why you have it 80 percent.

DR. HEATH: I'm still not clear with that answer though. Is there a time factor there?

MS. VERNIERO: No. There's not a time factor. I can tell you that the average length of time a person is on CCPED is nine months.

ASSEMBLYMAN THOMPSON: The 3300 is fixed by Federal funds available?

MS. VERNIERO: It's fixed by Federal and State.

MR. MUNIZ: What happens after those nine months? Do they move into a different level of care or a different facility or what?

MS. VERNIERO: Yes. Not everyone needs the service. They could possibly get other services that would not require CCPED or they do go into a nursing facility or they pass away or they go to the hospital.

MR. MUNIZ: If the average is four ATLS, most likely they're going to require more instead of less.

MS. MICHELSEN: They die or go to a nursing home.

MR. MUNIZ: Right.

ASSEMBLYMAN THOMPSON: Do you currently have a waiting list? If so, about how long is it?

MS. VERNIERO: Yes. We have a waiting list of approximately 175 people statewide.

ASSEMBLYMAN THOMPSON: And which would take an average of how long to actually get on the service?

MS. VERNIERO: The average waiting list, I mean, about eight to ten months.

ASSEMBLYMAN THOMPSON: Eight to ten months.

MS. VERNIERO: Yes.

ASSEMBLYMAN ROMANO: You said nine months. Why? Is there a cap at the end of this program?

MS. VERNIERO: No. It's just when you review the length of time individuals remain on the program it just averages nine months.

ASSEMBLYWOMAN MURPHY: That's not conditioned.

MS. VERNIERO: They could be on for four years. They could be on for five years, but the average statewide is nine months.

ASSEMBLYMAN THOMPSON: And currently, they have an eight- to ten-month waiting list to get on it, if they're not on it, right?

MS. VERNIERO: Yes. That's correct.

MR. MUNIZ: I'm surprised there's such a short waiting list -- 175 people. Why do these people not take so much advantage of it, at least to be put on the waiting list?

ASSEMBLYWOMAN MURPHY: But I think people come and go on it quickly.

MS. EDELSTEIN: The people also know there's a waiting list of eight to ten months.

ASSEMBLYMAN THOMPSON: Yes. She said an eight- to ten-month waiting list.

ASSEMBLYWOMAN MURPHY: Yes.

MS. VERNIERO: May I go on?

ASSEMBLYWOMAN MURPHY: Sure. I'm sorry, Marlene.

MS. VERNIERO: Oh, that's okay.

The second Medicaid waiver is known as the AL-AFC, Assisted Living and Alternate Family Care. That's our newest waiver in this state. It was begun in January 1996. We currently have approval to serve 1500 individuals, unduplicated clients, at any one time. Similar to the CCPED waiver, the waiver eligibility is similar: an individual 65 or older; if between 21 and 64 must be disabled; with a monthly income of \$1500 or less; assets 2000 or less. These individuals do not have to have their own health-care insurance, as they did with CCPED, but the individuals also need to be assessed. A clinical assessment must be done for needing nursing facility level of care so that the eligibility--

ASSEMBLYMAN ROMANO: Excuse me. Is Medicare Part *B* considered under health insurance?

MS. VERNIERO: Medicare Part *B* does come into play here. The individuals can pay Medicare Part *B*. If they do pay Medicare Part *B* with assisted living, that is considered an out-of-pocket expense for the short period of time that they pay, at the three months or whatever, and then they just flip right into Medicaid completely.

There are four types of assisted living with the waiver. One is assisted-living residence, which is apartment-style, purpose built facility. Each apartment has their own cooking unit. The second is known as a comprehensive personal-care home, which is typically shared occupancy rooms, shared bathrooms, renovated health-care facility beds. Assisted living program,

which is provided only to tenant of publicly subsidized housing. And alternate family care, which is in other states known as adult foster care.

The reimbursement for these four types is \$60 per diem for assisted-living residence, \$50 for comprehensive personal care, and \$40 each for assisted-living program and alternate family care.

We currently have 300 individuals served on the assisted-living Medicaid waiver. It's been very slow in developing, especially in the area of assisted-living residence. You may ask me, why that is? Probably, in some instances with the assisted living, it's so new. The business itself, the industry is new. They're developing their own programs, their own businesses. Many are waiting to sign up with Medicaid. We have less than 1 percent of the licensed beds currently occupied by Medicaid beneficiaries.

The alternate family care, or the adult foster care, component of the program is also growing slowly. There are some obstacles in that area that we're trying to eliminate. The ultimate family care providers, or caregivers, can currently care for up to three individuals at any one time in their home. However, if you have more than one person, you must be a licensed boarding house operator. Many municipalities do not allow or issue new licenses. So we're trying to eliminate that one barrier so that we can grow that program more.

ASSEMBLYMAN ROMANO: Excuse me.

You recall, Madam Chairperson, this was the issue. That's the State's way of getting around the issue that we had. They would call it a boarding house, but I understand there is legislation underway to broaden that

aspect depending upon the number of people that you have in the boarding house, not that you're going to have too many people in there, to allow that.

Could you possibly explain to me -- a little tough to understand sometimes -- foster care? You had foster care in there. Somebody adopts an adult or what?

MS. VERNIERO: No. Well, it's known as foster care in other states. In the State of New Jersey we refer to it as alternate family care. How it works is, a licensed agency is referred to as a sponsor agency. It could be a home health agency. They are licensed as alternate family care agency, or sponsor agency. That's what we call it. They recruit private homes in the community, an individual who becomes a certified caregiver, and they open their homes and bring in up to three individuals to live there and become members of their family -- similar to child foster care. They're not adopted, but they are accepted as a member of their family, and they live in that home as if they were a member of the family.

ASSEMBLYMAN ROMANO: Finally, are you now or have you ever been--

Get that everyone? (affirmative response from members)
(laughter)

ASSEMBLYWOMAN MURPHY: We got it. We're going to give you your law degree in two minutes. (laughter)

ASSEMBLYMAN ROMANO: Seriously, the situation-- I'm not going to go through that situation again because the Chairperson will slap me.

ASSEMBLYWOMAN MURPHY: Probably.

ASSEMBLYMAN ROMANO: But when you come to a situation where you've exhausted all these acronyms and programs, etc., what program is there that allows -- as I used in our last session -- a super manager to be able to provide-- The manager knows all the dimensions of the problem: the latitude, the longitude, the warp, the woof, however you want to say it, and then says this person needs two more hours or three more hours of health care. Is there such a program where this person can sign off? Because what we have now today with the cutback on the concurrent Medicaid review are hours being cut back. So people still want to keep their parents home. What is there that will pick up two hours a day or something of that nature? Because I've seen the situation where they've reached that gully, if you will, and now have said, "Can't keep them home. They've got to go to the nursing home," only for the want of two hours a day.

MS. VERNIERO: I believe you're referring to the those individuals who are at home on SSI and are eligible for generic personal-care assistance or personal-care attendant. The programs that I'm speaking about today are unique. They, in both instances, have care management, and the care managers have the authority to increase services if necessary or decrease services if individual's get better. There is some flexibility. These two programs--

ASSEMBLYMAN ROMANO: In Medicaid?

MS. VERNIERO: These two Medicaid waiver programs have flexibility built in because there is care management, but it's not an unlimited amount of money. We try to build into the program -- design some flexibility. We do have senior initiative programs that we're developing now, but

currently-- I understand what you're saying. I mean, Medicaid by definition is not the most flexible. There are regulations that we must abide by.

ASSEMBLYWOMAN MURPHY: What you're saying, I think, is that the personal-care program, which is a different program than either of these--

MS. VERNIERO: Yes, that's correct.

ASSEMBLYWOMAN MURPHY: --has very much more limitations on it?

MS. VERNIERO: Well, depending--

ASSEMBLYWOMAN MURPHY: And no care management?

MS. VERNIERO: I don't believe there is care management with that. I think there is just a prior authorization and, as the Assemblyman said, concurrent review, so an individual can authorize services. I believe it's out of the Medicaid district office, which is in the Department of Human Services. How I believe it works is a person, perhaps a doctor, authorizes the need for the service.

ASSEMBLYWOMAN MURPHY: Right.

MS. VERNIERO: And Medicaid district office authorizes the service, or maybe the hospital or the doctor authorizes the service and then concurrently someone from the Medicaid district office reviews that request to determine whether or not it's allowable or appropriate.

ASSEMBLYWOMAN MURPHY: If someone finished their hours on that personal-care service, could they enroll in one of these programs through case management?

MS. VERNIERO: They may be eligible to apply depending upon the two criteria, which is that financial eligibility--

ASSEMBLYWOMAN MURPHY: Right.

MS. VERNIERO: --and the nursing facility level of care. If the person has, say, the low assets but do not need nursing facility level of care, they would not be eligible for CCPED. These, remember-- HCFA allows alternatives to that institutional setting.

ASSEMBLYWOMAN MURPHY: And these are strictly used as an alternative to. You have to be--

MS. MICHELSEN: Yes, you have to meet -- when you go for CCPED, you have to pass the same physical assessment as you do if you're applying for a Medicaid nursing home.

MR. MUNIZ: Exactly. And that's the difference right there.

ASSEMBLYWOMAN MURPHY: Okay.

MR. MUNIZ: Marlene, only 300 people are taking advantage of these 1500 slots available, which is kind of ridiculous. Do you think that the reason is because of \$50 or \$60 that they're getting reimbursed? To provide the same level of care that is required at a nursing home -- that if you have a person coming into a nursing home, he will be getting at least \$100 or \$110 a day versus \$50, and this is a very strong qualification for a person to be eligible for one of these slots with the same eligibility requirements that a person would have for a nursing home.

MS. VERNIERO: I know that's an issue. But even in a nursing facility, there's a range of individuals in terms of what their care needs are. Other states do have reimbursement based on level of care need. We do not

have that here. At some point, we hope to review that kind of program, but we don't have that right now. We have a fixed rate of reimbursement.

I just remind you all, though, that the Federal regs require all states, every single one, that participate in Medicaid waiver programs that they cannot pay the same cost that can be paid to a nursing facility. It has to be less than. It could be equal to or less than.

ASSEMBLYMAN THOMPSON: That's part of the motivation of keeping people--

MS. VERNIERO: And that's-- The point of it is so that we could develop a choice and a home- and community-based alternative. So we could not pay the same or more than a nursing facility. That's just not allowed.

Another question?

DR. HEATH: These waiver programs. I understand that there has to be below the cost of institutional care. Do you have a feel of how New Jersey's ratio, if it was -- the cost of administering these programs in Jersey compares to other states' wayward programs? I would suspect at the level of reimbursement suggested here that we're maybe 50 percent, 40 percent.

MS. VERNIERO: Just tell me your question again. Where does New Jersey rate in terms of using home- and community-based alternatives or the cost?

DR. HEATH: The cost. The comparison of the cost of our waiver program perhaps as compared to how other states--

ASSEMBLYMAN THOMPSON: The ratio of the waiver versus the nursing home care.

MS. VERNIERO: The cost I don't know.

DR. HEATH: These programs achieve savings--

MS. VERNIERO: Right.

DR. HEATH: --because they're not putting people in a nursing home. So there's a ratio there. We're achieving percentage savings.

MS. VERNIERO: I don't know where our percentage savings compares to other. I know that right now the State of New Jersey is not-- Of our entire nursing facility -- or actually it's not the nursing facility budget because many of these programs have nothing to do. The nursing facilities are very well needed as well, as we heard today surely. These are just about developing choice, so an individual wants to go to a nursing facility that's their right to go. We just want to offer them the choice, and in many of these instances, the choice of living in their own home is cheaper.

DR. HEATH: I agree completely, but on the other hand, we argue that it has to be below a certain nursing home threshold cost -- choice -- but we're using the economic--

MS. VERNIERO: Well, because the Feds say-- They use a phrase called cost-effectiveness, and that's-- I live and breathe every day cost-effectiveness, and that's what I have to prove. And when I go to expand programs, Medicaid waiver programs that is, I must show cost-effectiveness. So it's in the aggregate, so I could probably go over cap with one individual, but at the end of the year, if I serve 1500 folks, I have to be within a certain budget, and it can't exceed those same people being served in a nursing facility.

MR. MUNIZ: It's cost effective, but it's not serving the purpose. It's not serving the people that there are so many people waiting to get into a nursing facility like that because not too many people want to accept these

people in their facilities. Many of the assisted-living facilities don't have any sort of mission. They do not take people with the waiver program. I believe that now the Marriott is starting to look into that area, right?

MS. VERNIERO: The who?

MR. MUNIZ: Marriott.

MS. VERNIERO: Marriott is enrolled in the Medicaid waiver.

MR. MUNIZ: So not too many people are willing to come in and to provide a same level of care that a nursing home would provide for half or less than half of the price of the cost.

ASSEMBLYWOMAN MURPHY: Now, do the people in alternate family care receive these dollars? This program covers alternate family care?

MS. VERNIERO: Yes. The Medicaid assisted-living waiver includes alternate family care as one of the components, so there's four different types. Yes.

MS. MICHELSEN: Marlene, when you say that Medicaid -- that Marriott has become a Medicaid provider for assisted living--

MS. VERNIERO: Yes.

MS. MICHELSEN: --can you tell us a little bit more about that?

MS. VERNIERO: Okay.

MS. MICHELSEN: When did it take effect? How many people? All the Brighton Gardens places?

MS. VERNIERO: No. They just began. They actually enrolled in May. It took them several months to get their organization ready. They had reviews, etc. They enrolled in May, and they've just begun to accept

clients now, so it took them a few months to get prepared. They're starting first with the one in Lakewood -- Brighton Gardens in Lakewood.

That particular program, the one that's being asked about, is what is known as an assisted-living residence, which is a new building. Currently today, there are 57 licensed assisted-living residences in this state. Thirteen of them have enrolled in the Medicaid Program.

ASSEMBLYWOMAN MURPHY: And are the residents in those 13 who are on Medicaid?

MS. VERNIERO: Very few. Less than 1 percent.

MS. EDELSTEIN: Marlene, when they enrolled, do they have to tell you how many Medicaid recipients they're willing to accept--

MS. VERNIERO: No.

MS. EDELSTEIN: --or is it on a case-by-case basis?

MS. VERNIERO: Okay, let me share that with you. Our regulations do not require a licensed facility to either become enrolled, so they don't have to be a Medicaid provider. And if they do become a Medicaid provider, they do not have to tell us how many beds/individuals/slots they want to have or how many individuals they will accept. So when we work with them-- As we work with them closely and get a close working relationship, they may share with us what they have in mind, but they are not required to, say, get X number of beds set aside for Medicaid. So they can change it. They can begin thinking maybe 10 percent, go to 20 percent, and go to 5 percent, so they're not required. There are no stipulations whatsoever. It's completely flexible at this particular time.

ASSEMBLYMAN ROMANO: I have to say you are very good and so is that gentleman. Did you replace Karen Squarrell? Are you the Director?

MS. VERNIERO: No, sir. I work for the Department of Health and Senior Services and--

ASSEMBLYMAN ROMANO: And you're not with the Human Services?

MS. VERNIERO: Right. I'm in the Department of Health and Senior Services in the Medicaid area in the long-term care.

ASSEMBLYMAN ROMANO: But that's a separate area, the PCA is under--

MS. VERNIERO: Yes, that's Human Services.

ASSEMBLYMAN ROMANO: Okay.

MS. VERNIERO: Any other questions? (no response)

Thank you.

ASSEMBLYWOMAN MURPHY: I thought there were nine Medicaid waiver programs?

MS. VERNIERO: Yes, there are. There's nine, but today I'm here to talk about two because those two have services for the elderly. The other seven--

ASSEMBLYWOMAN MURPHY: Yes.

MS. VERNIERO: --are administered by the Department of Human Services, and they are things like Medicaid ABC for children, medically fragile children, the A-Cap waiver, which is for AIDS individuals.

ASSEMBLYWOMAN MURPHY: Okay, thank you.

MS. VERNIERO: There's one for DD individuals, traumatic brain injury, model waivers for folks who are profoundly disabled. So those are seven other waiver programs that are administered by Human Services.

ASSEMBLYWOMAN MURPHY: Okay.

MS. VERNIERO: Okay. Thank you.

ASSEMBLYWOMAN MURPHY: Thank you very much, Marlene. We appreciate your coming.

Migraine headache time. We need to talk a little bit about dates. We need to talk a little bit about agendas for the next focus.

Peggy, do you want to come up. I'm going to dislodge you only because we talked about some dates. Do you have those?

MS. NELSON (Majority Aide): I hope so.

ASSEMBLYWOMAN MURPHY: So do I.

The assumption in my mind at this point, ladies and gentlemen, is that we will have a final report into the Governor by the end of June, which means we don't have an awful lot more time in which to move along with this.

John Heath, I had hoped that you would present or have some presentation for us relative to education, palliative care, alternate choices.

DR. HEATH: I would be happy to talk a bit about education. I had contacted a colleague -- a doctor of theology actually. He's within the UMD system.

ASSEMBLYWOMAN MURPHY: Correct.

DR. HEATH: He had worked with a prior legislative colleague during New Jersey's process of getting advanced directive legislation through and has followed it since. I have been in contact with him, and he was

checking his schedule and was anticipating hearing when our next meeting was. I shouldn't say next meeting, at some future meeting, but he would be willing to make a presentation about how the advanced directive process has kind of worked within the state and some of his thoughts about thinking about ethical decision making in the government's role. I had actually faxed a copy of the letter to Peggy.

ASSEMBLYWOMAN MURPHY: Yes. And having that, I'm just wondering if those things couldn't all be put into one meeting. Does that not make sense to you coming from that aspect? So we'll let you run with setting that up in communication with Peggy and with Ruth to talk about-- I write things down, and then I write so many of them down I lose track of them--

DR. HEATH: Professional education needs.

ASSEMBLYWOMAN MURPHY: Professional education needs, palliative care, which is pain--

ASSISTANT COMMISSIONER READER: Do you want John to deal with that, Assemblywoman, or did you want Bonnie to talk about her grant for palliative care?

DR. HEATH: I'd feel more comfortable talking about the educational aspects, and I would defer to someone else about palliative care, frankly.

ASSEMBLYWOMAN MURPHY: Now, what is--

ASSISTANT COMMISSIONER READER: There's also an excellent person out of -- Is it Cooper? -- on palliative care that is working on that grant with us.

ASSEMBLYWOMAN MURPHY: Okay.

ASSISTANT COMMISSIONER READER: I think she would be a good presenter.

ASSEMBLYWOMAN MURPHY: Okay.

MS. NELSON: So that's Bonnie? I'm having trouble--

ASSEMBLYWOMAN MURPHY: You have to get the names after. It will be Bonnie and whoever because I don't have his name.

MS. NELSON: No. No. No. But I'm just trying to figure out who I talk to because when I go home I have no name--

ASSEMBLYWOMAN MURPHY: Ruth.

MS. NELSON: --then I have real trouble.

ASSEMBLYWOMAN MURPHY: Ruth and Bonnie.

Living wills. Isn't that what we just talked about, John, was living wills, and you have--

DR. HEATH: I've extended an invitation. I haven't had a response yet.

ASSEMBLYWOMAN MURPHY: Okay. You will follow up with that though?

DR. HEATH: Yes.

ASSEMBLYWOMAN MURPHY: Thank you very much. Or Peggy can.

Are there other issues that tie in with that that makes sense in that piece?

ASSEMBLYMAN ROMANO: Madam Chair?

ASSEMBLYWOMAN MURPHY: Yes, sir.

ASSEMBLYMAN ROMANO: The Alzheimer's appears to be the most heaviest of all issues here that we have to direct ourselves to.

ASSEMBLYWOMAN MURPHY: Right.

ASSEMBLYMAN ROMANO: And that was yesterday in our own budget hearings, okay.

ASSEMBLYWOMAN MURPHY: Yes.

ASSEMBLYMAN ROMANO: I see that as a major problem. What do we do? How do you keep somebody with Alzheimer's at home without tying you to the bed?

ASSEMBLYWOMAN MURPHY: Ruth.

ASSISTANT COMMISSIONER READER: I wonder, if as a part of professional education, this is an opportunity to bring in the education around caring for an Alzheimer's person. Remember several people mentioned--

ASSEMBLYWOMAN MURPHY: Yes, they did speak about that.

ASSISTANT COMMISSIONER READER: --the fact that they felt the people coming in were not well prepared to deal with Alzheimer's.

Roberto alluded to that after the public hearings that he's added training here. Is there someone who should address that?

MS. MICHELSEN: Talking about the education of the home health aides themselves--

ASSISTANT COMMISSIONER READER: Yes. Yes.

MS. MICHELSEN: --not the caregiver education, but the actual certification process for home health aides. The home health aides are coming

in supposedly knowing how to handle the demented person. They have no idea.

ASSISTANT COMMISSIONER READER: And what to that extent, also, to the nursing facilities is it across the board for certified health aides no matter where they work.

ASSEMBLYWOMAN MURPHY: Okay. So who would deliver that kind of discussion for us?

ASSISTANT COMMISSIONER READER: I don't know the answer to that.

MR. MUNIZ: Would it be someone from the Alzheimer's Association?

ASSISTANT COMMISSIONER READER: Rick says he'll find someone.

MS. MICHELSEN: I would think it would be somebody in licensing and certification.

ASSEMBLYWOMAN MURPHY: Susan runs the Alzheimer's group, yes.

ASSEMBLYMAN ROMANO: She's been at the other meetings.

ASSEMBLYWOMAN MURPHY: Yes, she has.

Those issues I would think would take care of a meeting.

MR. MUNIZ: Madam Chair.

ASSEMBLYWOMAN MURPHY: Sure.

MR. MUNIZ: How many more meetings do we anticipate?

ASSEMBLYWOMAN MURPHY: I'm frankly looking at two more meetings and then one last public hearing in Trenton. I would love to

hear from the baby boomers. I've no idea how you attract them -- that age-group that is going to get caught in three generational problems: their grandmothers, their mothers, their kids, and themselves. What are they going to do? How are they going to deal with this? How are they going to live?

ASSEMBLYMAN ROMANO: Madam Chair, I hate to dominate things like this--

ASSEMBLYWOMAN MURPHY: Oh, yes, you do. I know that.

ASSEMBLYMAN ROMANO: --but I'm totally restrained.
(laughter)

ASSEMBLYWOMAN MURPHY: I love it when you restrain, Lou. I love you when you restrain. (laughter)

ASSEMBLYMAN ROMANO: This is a problem right now in our budget hearings. I sit on the budget committee. There's a tendency on all parts for people to come up with needs and say, "Let's charge it to the tobacco money." Everything is now tobacco money.

ASSEMBLYWOMAN MURPHY: Yes, I know.

ASSEMBLYMAN ROMANO: When they talked about the tobacco money going in part for KidCare, I have found an inordinate number of -- you call them yuppies, is that what it is? -- yuppies--

ASSEMBLYWOMAN MURPHY: I call them baby boomers.

ASSEMBLYMAN ROMANO: --baby boomers, whatever the case is, who don't have health insurance. And they're going day to day without health insurance. Now, what we've lost in New Jersey two years ago was the access program, which was a bare-bones program. Now, when you say talk to them, they're not senior citizens, obviously, but it's very hard for them to come

up with an inexpensive program, which was very competitive when they had it, and then they ran out of the money, and nobody ever reinstated it again.

And lastly, there has to be something in here for senior citizens. I might even say people after 50, never mind even senior citizens, to give them a break on pharmaceutical prescriptions. There's got to be a higher cusp than-- And you can even see here with the numbers how-- And if you know the numbers in your mind about the PAAD Program, we're talking about poverty. Now, what's one step up from this here? What do we do? Pharmaceuticals are very expensive. We're not saying that the State should absorb the cost for the entire program. The Federal government won't absorb it under Medicare, least of all we would expect that from the State. We can't do that -- expect that from the State, but maybe there is some ingenuity with finance that they can have a program that buying through the State is always cheaper, so that they pay with co-pays -- higher co-pays -- depending upon the medicine.

In that concert, I have a couple of young people who don't have health benefits and who have to pay for their own pharmaceuticals. They're in the guise of when they do have to pay, \$68, \$88, \$110. I think that we're missing something here. There's got to be a way to include people, like a last-ditch effort. Look, you want to join this program -- is going to be, depending upon the cost of the medicine or whatever the case is, a 10 co-pay or a 20 co-pay. Much better than spending \$68.

ASSEMBLYWOMAN MURPHY: Right. I hear you.

ASSEMBLYMAN ROMANO: That's all I have to say today, Father. Bless me, Father, for I have sinned.

ASSEMBLYWOMAN MURPHY: Or mother as the case may be, okay.

I'm going to mention something else. John Michael Heath, M.D., associate professor, Family Medicine, and codirector Geriatric Medicine Fellowship Training Program received a 3-year, \$299,000 grant from the Robert Wood Johnson Foundation through its New Jersey Health Initiatives to study linking community-based geriatric health care with adult protective services. Congratulations.

ASSISTANT COMMISSIONER READER: Great. Excellent.

DR. HEATH: Thank you.

ASSEMBLYWOMAN MURPHY: And along that line, if we are talking about elder abuse, do you want to talk about that, too?

DR. HEATH: We'd better hear from people who know that firsthand, from the people in the trenches. I'm doing linking, but--

ASSEMBLYWOMAN MURPHY: I'm just wondering if we shouldn't hear about alcohol -- alcoholism, that kind of thing, if you will, and elder abuse also.

Can I leave that to you, Ruth?

ASSISTANT COMMISSIONER READER: Yes.

ASSEMBLYWOMAN MURPHY: Thank you.

But congratulations, John. We're really very proud of you.

DR. HEATH: Thank you.

ASSEMBLYWOMAN MURPHY: And we're also delighted since you've been appointed to the Advisory Council on Elder Care.

DR. HEATH: Yes.

ASSEMBLYWOMAN MURPHY: That was very nice, too. Thank you.

That ought to really take us--

Yes.

ASSISTANT COMMISSIONER READER: I thought about the baby boomers. In talking to one of the other states that's done a similar thing, they actually advertised the public hearing for baby boomers, and they were astonished at the people that responded. They had more than one hearing from baby boomers.

ASSEMBLYWOMAN MURPHY: I'd love to do this.

ASSISTANT COMMISSIONER READER: So I think it would just be a matter of actually putting a date and a place in the paper and asking people to call Peggy to register.

ASSEMBLYWOMAN MURPHY: Everyone in my office just quit. You know that don't you? (laughter)

But, seriously, they're the group that's really going to take this on the chin, and if we aren't hearing from them--

MS. EDELSTEIN: I think to get a showing of people you either have to do an evening or a weekend.

ASSEMBLYWOMAN MURPHY: It's okay with me. I somehow think we can't come to closure on this until we have heard from the group that is going to be the most incredibly impacted.

WILLIAM R. ABRAMS: (speaking from audience) Carol, when you look at the focus of baby boomers, the one issue that we're so concerned

about is how are you going to finance -- and I'm not only talking about nursing homes--

ASSEMBLYWOMAN MURPHY: Yes.

MR. ABRAMS: How are you going to finance it in the future, and you see that baby boomers are critical to focus in on. Because when we look at the whole concept of long-term care insurance, the folks that are in the long-term care facility, it's, if you will, too late to talk about insurance for them.

ASSEMBLYWOMAN MURPHY: Absolutely.

MR. ABRAMS: But if the individual in their early 40s, late 40s--

ASSEMBLYWOMAN MURPHY: How about the middle 20s who should be when they go into a company?

MR. ABRAMS: I think that's an important thing. Needless to say, my members always like to talk about the fact that they provide services that people need but certainly don't want, and because it's not happy things, people don't want to think about it.

ASSEMBLYWOMAN MURPHY: Oh, tell me about it.

MR. ABRAMS: The whole concept of long-term care insurance -- the whole concept to refashioning how we pay for all levels of long-term care delivery and pharmaceuticals, it's not a short-term fix, but rather a long-term investment. We have a great opportunity given our robust economy--

ASSEMBLYWOMAN MURPHY: Right. Okay.

MR. ABRAMS: --to put together a comprehensive plan and fix it now.

ASSEMBLYMAN ROMANO: We have to talk in terms of to -- or consider, rather, when you talk about yuppies and baby boomers and all that stuff, when you talk of college graduates who have gone on for, let's say, white-collar sort of positions, they're very attuned to the fact about health insurance, and they might be concerned about nursing home insurance. We take a blue-collar, who right now it's difficult to hold a job -- you're moving quite often -- basic health insurance becomes a problem. The only way you're going to have people really get concerned about nursing home insurance is the contracts of various union-affiliated people. You know how we've come over the years. Lately, however, we're in a slump where they're not getting everything that they want, but they were looking for legal defense. Okay. This might very well be an issue that will come up in labor contracts. Do you follow me?

ASSEMBLYWOMAN MURPHY: Yes.

ASSEMBLYMAN ROMANO: Anything that becomes, and I hate to say it this way, not subject to income tax--

ASSEMBLYWOMAN MURPHY: Right.

ASSEMBLYMAN ROMANO: --is a program that they would like to have given to them for free because they belong to a certain unit and make it part of their negotiations. Right now, negotiations is on the hard part because there are too many efforts to cut down their domination of certain professions.

ASSEMBLYWOMAN MURPHY: There are also-- There's an article that we read not too long ago, a lot of small employer companies, 50 to 100 employees, are beginning long-term care insurance offerings. It is the

offering of it that you can start when you don't have to pay the \$1000 or \$2000 a month that makes it attractive to you. There need to be some tax incentives with this, too.

MR. ABRAMS: You know, there's a bill that's sponsored by Marion Crecco and Guy Gregg that would provide tax credits in return for the purchase of long-term care insurance.

ASSEMBLYWOMAN MURPHY: Right.

MR. ABRAMS: The Assembly version is in the Appropriations Committee, but the industry kind of-- What we did is that we not only made it applicable for businesses, but also for individuals.

ASSEMBLYWOMAN MURPHY: Right.

MR. ABRAMS: And not only for themselves, but also for their moms and their dads, and what we've done is we've graduated the tax credit.

ASSEMBLYWOMAN MURPHY: Who can come in and speak about this with knowledge? I know that we have a couple of people who would like to come and talk about it. Does anyone else have people?

MS. NELSON: Susan has somebody from out West someplace. She got permission from the Governor's Office.

ASSEMBLYWOMAN MURPHY: Okay. Oh, that's right.

MS. NELSON: I don't know anything about it.

ASSEMBLYWOMAN MURPHY: Okay. We'll work with Susan Reinhard, I mean. She's got a task force studying long-term care. She has a committee/task force studying this.

ASSEMBLYMAN THOMPSON: In fact, Lou threw out something there -- mentioned labor, etc. Do you think that labor has

something to say here, organized labor, because they do have their health-care sections, and so on, and some of the concerns that they might have?

ASSEMBLYMAN ROMANO: Right now, labor in general is trying to hold the line on what they have because we're in a new era now called givebacks, so they're not about to come up with an issue that is going to say, "Don't you know when enough is enough?"

ASSEMBLYMAN THOMPSON: No. When they come to talk to us, they're not talking to an employer trying to go out on a strike or anything, but talking about what they see that we need to do.

ASSEMBLYMAN ROMANO: There's a lot of this. I have no problem. We could do that, but right now I don't think that their attention is drawn to these types of things.

ASSEMBLYWOMAN MURPHY: All right. We're going to set a couple of dates right now.

MS. NELSON: We still have to hear from the hospital people.

ASSEMBLYWOMAN MURPHY: Okay.

MS. NELSON: Because they were in on the day that we missed.

ASSEMBLYWOMAN MURPHY: Okay. You have to tell me what you mean -- hospital people.

MS. EDELSTEIN: There are three people that I had that were set to testify on the 26th of February, which is the meeting we had to--

ASSEMBLYWOMAN MURPHY: Right. In what regard?

MS. EDELSTEIN: Care management, discharge planning, and the role of integrated delivery systems.

ASSEMBLYWOMAN MURPHY: Okay. Care management, discharge planning, integrated delivery. Okay.

I will tell you that just recently I've been having calls relative to a 23-year-old with alcohol and drug problems, DWI, no car, no insurance, surcharges, been arrested in Newark, picked up on a charge, who is on methadone. You talk about care management. Does that family need care management or what? And there is no one who will hold the umbrella and say, "All right, I'll hold your hand, and we'll get this and this and this and this." It's really very difficult. So case management/care management, whatever you call it, everyone needs it.

ASSEMBLYMAN ROMANO: That's hard. That's a very difficult topic, what you're talking about, because there seems to be no daylight--

ASSEMBLYWOMAN MURPHY: None.

ASSEMBLYMAN ROMANO: --in those situations. It never ends.

ASSEMBLYWOMAN MURPHY: Nope. There's no way--

ASSEMBLYMAN ROMANO: There's no one set way.

ASSEMBLYWOMAN MURPHY: And there's no one center that will say, "Okay, we'll put people together to do the talking to take care of this." It's really kind of fragmented.

Okay.

ASSEMBLYMAN ROMANO: As a legislator, you've picked up problems from people where, in effect, you and I have become care managers, but you can't do it all the time because you are not in that business.

ASSEMBLYWOMAN MURPHY: I said to Peggy, I wanted to quit my job as a case management person. Number one, I don't do it very well, and number two, it's driving me nuts.

MS. NELSON: And it takes so long.

ASSEMBLYWOMAN MURPHY: Okay. We are now today at the 5th of March and the month is whizzing by. What were the dates we wrote down as we spoke the other day?

MS. NELSON: Well, we did have a problem with the dates that we thought we were sending to you all. They just did not work, so we're back to square one.

MR. MUNIZ: Are we talking about next month?

MS. NELSON: We're talking about probably at least one in this month if we can do it.

ASSEMBLYWOMAN MURPHY: We started with March 31, I believe.

ASSEMBLYMAN ROMANO: Are you aware that in this very same place on Friday, March the 12th--

ASSEMBLYWOMAN MURPHY: You are coming?

ASSEMBLYMAN ROMANO: No. It's the American College of Health Care Administrators?

ASSEMBLYWOMAN MURPHY: Yes.

ASSEMBLYMAN ROMANO: Their annual meeting.

ASSEMBLYWOMAN MURPHY: Yes.

ASSEMBLYMAN ROMANO: Are you coming?

ASSEMBLYWOMAN MURPHY: No. I have an SICC meeting.

MR. MUNIZ: I invited everyone, so hopefully, you got an invitation. We're looking forward to seeing some of the Assembly.

ASSEMBLYWOMAN MURPHY: How about the 31st of March?

MS. NELSON: We went all through this, Carol, and this is what I ended up with. We're talking too many people not here.

ASSEMBLYWOMAN MURPHY: So where did you--

MS. NELSON: We didn't. I lost my agenda, remember, and attached to it was the--

ASSEMBLYWOMAN MURPHY: We'll have to get back to you then.

MS. NELSON: Well, no, I asked everyone to come with dates that would work for them somewhere between now and April 23 because--

ASSEMBLYWOMAN MURPHY: What do you all have free the first week of April? There's only two days in that week?

ASSEMBLYMAN ROMANO: What do you mean there's only two days?

ASSEMBLYWOMAN MURPHY: April 1 and April 2? (members discuss dates)

Okay, 1:00, Friday the 9th, New Jersey Hospital Association, unless you hear differently, and that is located in or about Princeton.

So, Sam, you can fall out of one place and into the other.

We will send you an address, and we will seek to have the care management--

I'll put this in your hands, Theresa.

And then we will try to get long-term insurance come in that same day. I'll speak to Susan Reinhard and see if we can't combine those things together.

And then the next meeting following that, which I would, also, like to get in the next week, if we could, what days do you have? (members discuss dates)

All right, that's another meeting date. Don't close the books. We've got two days pretty well full, and you have a nighttime for elder care. If you want to put assisted living and that kind of thing-- Believe me, I don't disagree with you, we have to really move that sometime into March.

All right, ladies and gentlemen, on the 15th of April in the afternoon, we will do assisted living. Now, all these agendas, just hold the dates. We have to contact people to make sure they're going to get there. We may have to shift people around. Elder Care in New Brunswick in the afternoon on the 15th.

Okay. Thank you. Thank you. Thank you all.

(MEETING CONCLUDED)